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## Original Articles.

## ALBUMINURIA.\*

BY JOHN DICKSON, M.D., OF BALTIMORE.

This paper will not attempt any original views, or even novelty, upon the subject of albuminuria, but merely present some practical thought on its various forms and treatment. That the presence of that substance in the urine is not looked upon with the same degree of alarm now as it was a few years ago, is due to a larger intelligence upon the subject and more prompt and efficient methods of treatment. Even yet the popular notion is, that if a doctor acknowledges his patient to have Bright's disease, it is equivalent to signing his death warrant.

Now we have all had cases that were so discouraged, years ago, that if we had not been very patient with them, they would either have succumbed to their disease or left us for other methods of practice; and yet they are our warmest friends to-day for the benefit which we have been able to render them, and the hope that we have given them for their future.

I have several patients now of various ages, but mostly in advanced years, who have had more or less non-organic albuminuria for many years, and by judicious care, they seem to enjoy as much health as most of their age, who have no such symptom. Even in some of the aged, where there is anæmia and a tendency to œdema of the feet and ankles, life with a reasonable amount of strength and comfort has been preserved beyond the allotted three score and ten years.

In the *Lancet* of Oct. 17, 1885, Dr. Pavy mentions a form of intermittent albuminuria, which I have several times seen in persons of fair health, but who have had their attention drawn to their urine from apprehension of kidney trouble.

Their morning urine is normal, but after breakfast or dinner it is more or less charged with albumen. Dr. Pavy says the same thing occurs with regard to certain urines that deposit phosphates.

He calls this form cyclic albuminuria not because these are cyclical physiological changes, but rather that the personal habits of the patient produce this result, from the ingestion of too much albuminous food, eggs, etc. Or on the other hand, from deranged digestion, liver disturbance, over fatigue, and innervation from various causes.

Mr. G. C., a merchant, aged 55, of perfectly steady habits and regular life, has had more or less albumen in his urine for the last ten years. His business has led him to visit malarial districts of country once or twice a year, and he has had some evidences of malarial blood poisoning, at times. But on the whole, his health has been good enough for the regular pursuit of his business, and he would not like to be considered an unhealthy man. The most serious symptom he has had, has been anasarca which was relieved several times by Turkish baths and it is now about three years since he has been troubled in that way. The albuminuria, however, continues.

Mrs. K., aged 76, for more than ten years has had symptoms of albuminuria, with gastric disturbances frequently, with alarming heart symptoms and two attacks of phlebitis; once in the arm and once in the leg. These have been followed by œdema of the feet and ankles, and the urine seldom without some trace of albumen.

Under careful treatment, principally by iron and ammonia, diaphoretics, warm baths and occasional laxatives, she now enjoys better health, at her advanced age, than for many years past.

The tendency to venous congestion has also very much lessened, and her powers of locomotion are very fair. I have not heard a complaint of indigestion for more than a year and she enjoys the pleasures of the table with an epicurean relish, modified by experience.

Some very interesting experiments showing the value of the warm bath treatment are mentioned in the *N. Y. Medical Record* of March 30th, 1886. They were made by Dr. Korkunoff, of St. Petersburg, Russia. The patients were under observation eight days; dur-

\*Read before the Baltimore Medical Association April 12, 1886.

ing the first four without any treatment but confinement to bed. Then for the next four days they were given two daily baths  $101.75^{\circ}$  F., of an half hour's duration. The conclusions were: 1. "The absolute daily amount of albumen in bath days is mostly smaller than in days without baths. 2. The per cent. amount of albumen also lessons under the influence of baths. 3. The weight of the body invariably decreases, the decrease being proportionate to the amount of dropsy present; that is the more dropsical the patient is, the more considerable is the loss in his weight. 4. The amount of urine invariably lessons, but the specific gravity increases in spite of the fact that the amount of water ingested by the patient is always larger during the diaphoretic treatment. 5. The loss of water by the skin and lungs is considerably increased by the sudorific treatment.

In all the cases dropsy rapidly disappeared or greatly diminished under the use of baths.

From the fact that the absolute and per cent. amount of albumen is diminished by the diaphoretic treatment, the author deduces the practical corollary that warm baths act not only symptomatically, but also produce a favorable influence on the morbid process in the kidneys, for by their diminishing the excretion of albumen they stop the progress of general exhaustion of the patient and relieve the irritation caused to the kidneys by the egress of albumen."

These experiments of Dr. Korkunoff, and his conclusions as to the benefit of warm baths, for the most part correspond with my own experience and observations; but in chronic nephritis we cannot always expect such happy results from any form of treatment.

*The causes* of albuminuria are so clearly proven in Dr. W. H. Dickinson's valuable work on that subject, that I beg to quote a few sentences from it.

"Albumen is a colloid body which transudes with difficulty; its passage through the apparatus of renal dialysis may be generally accepted as an indication that the machine is mechanically

imperfect, or is working under unusual pressure.

The urine is albuminous because it is mixed with serum, or at least with its albuminous constituent, which has passed from the blood-vessels into the urinary ducts. There are three conditions mainly which are associated with this unnatural leakage. Two relate to the blood-vessels, one to the tubes.

I. Congestion; undue pressure within the vessels supplying the glandular structures.

II. Lardaceous change in blood and vessels, which is accompanied by transudation of liquor sanguinis.

III. A loss by the secreting tubes of their epithelial lining, in consequence of which they readily yield passage to fluids which otherwise could not traverse them unaltered.

1. Taking these conditions one by one, congestion is shown to be a cause of albuminuria, both by the observation of disease and by experiments upon animals. The malpighian bodies are knots of blood vessels enclosed within the convoluted tubes; an increase of pressure upon the blood within them causes a transudation of serum into the tube; if the pressure be further increased, blood corpuscles also pass out either by migration or rupture. If a ligature be placed upon one of the renal veins these results follow. The urine becomes either albuminous or bloody according to the amount of congestion produced.

Such results follow from congestion associated with cardiac obstruction in the human subject. Similar results may follow when the congestion is not of this passive and mechanical nature, but is of the active form produced by a renal irritant. It is probable that, in certain circumstances, the same transudation may be poured into the tubes from the capillaries which lie outside them.

2. In the second place, there is a change in the vessels themselves, which occurs as the essential element in the lardaceous or amyloid disorder, in virtue of which they become unnaturally permeable, or apt to give exit to portions of their contents. The liquor sanguinis or much that belongs to it, appears to transude



in this complaint from the affected vessels wherever they happen to be. Such a transudation takes place into the solid tissue of the liver and spleen, from the surface of the stomach and bowels, and many other situations. The effusion may be so placed as to accumulate within the tissues and intestines of solid organs, or to pass as a discharge from a free surface. The position of the affected vessels determines the result. The malpighian vessels hang loose and free, so that any exudation from them passes into the tubes and mixes with the urine, while the same emanation from the intertubal vessels passes into the intestines between the tubes, and may give rise to new fibroid growth in that situation. When the change happens to affect the malpighian arteries, the escape of liquor sanguinis, as one of its results, necessarily renders the urine albuminous.

3. In the third place, it is found that there is a diseased condition of the renal tubes, which generally co-exists with highly albuminous urine.

The tubes consist, in health, of a simple membrane, immeasurably thin, upon one side of which are capillary blood-vessels, on the other side epithelial cells. This is the type of all glandular structure. It is probable that the fluid part of the blood can readily permeate the simple walls of capillary and tube, and thus is brought in contact with the epithelial cells. In the cell lies the power of the gland. It acts, after its kind, upon the fluid presented to it, by the basement membrane, and by the exercise of its functions, selects and manages the materials which are to form the secretion.

When the epithelial cells are removed the fluid of the blood having traversed the homogeneous membrane, can pass into the tubes without hinderance or modification.

Such, then, increased determination of blood to, or retention of blood within the organ, textural changes in the vessel walls, and loss of the protective epithelium of the tubes, are the immediate circumstances which occasion the admixture of the albumen with the urine."

The various renal tube casts which are

seen by the microscope are modified by the above conditions of change, and may contain epithelial cells, pus globules, blood disks, etc., according to the nature of the case.

A careful study of these casts gives a valuable insight into the nature of the disease. In addition to the fibrin which generally forms the bodies of urinary casts, sometimes cylinders are found made up so completely of compacted epithelial cells so as to render almost imperceptible the fibrin that holds them together.

Sometimes the casts are so large as to contain one or more of smaller calibre, showing their formation and escape from difficult parts of the tube.

A study of these appearances would require an elaborate article for itself, and we must pass them with a bare mention now, that imbedded epithelial cells indicate a catarrhal or inflammatory state of the tubes; pus cells, that the inflammation is extending and pus globules taking the place of epithelial cells. "Blood globules will show that there has existed enough congestion to rupture, or at least create migration through the malpighian capillaries."

Most of us have had occasion to watch with anxiety the appearance of albumen in the urine of patients convalescing from scarlet fever.

If there is no oedema or anasarca and the urine is flowing freely, and the patient complains of no bad symptoms, dimness of vision, or nausea, we have no cause for alarm, but any of these signs are enough to warn us of danger, and to prompt us to the most energetic measures for the relief of the congested kidneys, and the prevention of uræmia.

A very striking example of this kind occurred in my practice a few years ago. A bright mulatto girl of 13, had a slight attack of scarlet fever, with very little constitutional disturbance and scarcely any throat trouble. It was hard to keep her in bed for a few days, and when she got up, she was able to help her mother and three of the other children who were attacked about a week after. The mother's case was malignant from the outset, with violent delirium, diphtheritic

throat, etc. The three children were sick enough, but went through it bravely as did the mother, in spite of my fears. But during their convalescence the girl who had helped to nurse them all, suddenly complained of headache, became puffy about her eyelids, face to abdomen swelled rapidly, her urine was scanty and highly albuminous, vomiting and convulsions followed and coma ended the scene in less than a week from the first appearance of danger. I called Dr. Taneyhill to aid me in my efforts to rescue this patient from the fatal result, and no pains were spared in the most heroic treatment of the case.

The four other cases whose conditions were so much more serious at the outset recovered without any unpleasant sequelæ whatever.

In severe cases of diphtheria the urine is charged with albumen and that is an important diagnostic sign of difference from it and croup.

As in pneumonia and in other febrile affections it is of transient duration and only the result of functional kidney disturbance, disappearing with convalescence.

Dr. Wm. Squire, in his article on Diphtheria, shows that the presence of a considerable amount of albumen does not interfere with the large excretion of the urea which accompanies the progress of that disease. In one of his cases thirty-one determinations of the quantities of albumen and urea were made from sixth to the thirty-seventh day of the disease. "On the tenth day when the albumen was estimated at one third, the quantity of urea was twice as much as is normally excreted, the specific gravity being 1016; it was not until the thirty-seventh day that the urea fell to its normal quantity, and albumen was for the first time absent; the specific gravity had then fallen from 1015 to 1010. Subsequent observation on the forty-seventh, fifty-fourth and sixty-second days agreed very closely with the last result. The albuminuria is not be as solely dependent on an original change in the blood, but chiefly upon a morbid process in the kidney, which is one of the disseminated lesions of structure oc-

casioned by the general disease. Congestion of the malpighian tufts is an early lesion, followed by further change in the tubular structure of the kidney. A relation is found between these changes and the amount of albumen, but no constant relation between the albumen and the amount of blood change." Many instances, however, occur in which the functions of the kidney may be seriously impaired or even suppressed.

But as long as the urine flows with normal freedom and quantity, without tube casts or blood corpuscles, and its specific gravity keeps up, we may hope that the albuminuria will disappear in time, without serious results.

Mr. C. M., a merchant, aged 45, early in May last, was seized with all symptoms of follicular tonsillitis, pains in the back and limbs, chilliness, sore throat, fever, etc. Having observed these symptoms as often preceding an attack of acute rheumatism, and he being of a rheumatic diathesis, I treated him as on a former similar occasion, with tinct. of iron and salicylate of sodium.

As soon as the throat trouble began to subside, four or five days from the outset of the attack, unpleasant head symptoms came on. Violent shorting pains across the forehead and confused vision at intervals. The urine was examined at once and found scanty, brown, of high specific gravity and highly albuminous, one-half in volume.

Purgatives, hot baths and emulsions were assiduously administered, but in spite of the prophylactic energy of treatment, uræmic convulsions came on and lasted with irregular intervals for about three days, during which time he was, for the most part, in a state of coma, with stertorous breathing, and his condition seemed almost hopeless. I then called my friend Dr. P. C. Williams in consultation, and we decided to test the effect of jaborandi in addition to the other means used. This produced profuse diaphoresis and salivation and by thus supplementing the imperfect action of the kidneys, overcame the uræmic symptoms, until a gradual restoration of their normal function was effected. The rheumatic state was soon subdued by



the previous treatment, and the albuminuria disappeared until recently, when a similar attack of tonsillitis and rheumatism revived the symptoms of the previous attack of ten months ago, but in a milder form, and without any approach to the uræmic state. The amount of albumen did not exceed one-fourth in volume this time, and subsided more rapidly than in the previous instance, and the excretion was not lessened as before.

The only difference in the treatment in the latter attack was in the frequent administration of sal-rochelle and potass. bicarb. which acted like a charm whenever any rise in temperature or unpleasant head symptoms came on.

I am glad to say that he is convalescent again, without a trace of albumen in his urine.

In the first attack, I forgot to say that there was considerable cedema about the eyes, face and joints, but in the recent one, it was confined to the ankles and wrists, in one of which it continued so long that I resorted to a fly blister for its effectual removal. I have found this summary method a very beneficial one in many such cases, in spite of its seeming simplicity and harshness. There is always objection to it on the part of the patient or his friends, but I have never known one to object to it after he has once experienced its good effect, both in relieving the pain and in giving a sense of more freedom to the joint, by lessening the congestion of the tissues inflamed.

*Acute Albuminuria of Possibly Traumatic Origin.*—In the *New York Medical Record* of July 11th, Dr. Walter F. Morgan writes that he "was recently in attendance upon a boy, seven years of age, and had considerable difficulty in making a diagnosis until an analysis of the urine revealed the presence of fifty per cent., by volume, of albumen.

This condition had not been preceded by any specific fevers or other of the generally recognized causes of acute Bright's disease in children. Possibly it may have been due to a fall on the back which the patient had had about a month before.

The fall had been succeeded by a gradual deterioration of health, with great disturbance of the heart's action, convulsions and cyanosis. During the convulsive attacks the heart beats were irregular and about forty to the minute.

An unfavorable prognosis had been given, but, after a month of close attendance, Dr. Phillips and myself had the pleasure of seeing convalescence begin. Diplopia and incoördination of the muscles of locomotion persisted for several weeks, but the patient is now in perfect health."

What the treatment was is not given unfortunately, or more light might be thrown upon the subject.

In a paper recently read by Dr. W. M. Carpenter, of New York, before the Medical Society of that State, he gives a very striking case of albuminuria occurring with glycosuria in a "woman of 55 years of age, who had been in good health up to one year previously, when she noticed that she passed on some days more than the usual quantity of urine. No other symptoms were developed until it was seen that there was swelling under her eyes. That of the feet soon followed, with difficulty of breathing and physical signs of cedema of the lungs. The urine was examined then, and found to contain a sufficient quantity of albumen to solidify nearly its entire bulk. The specific gravity was 1.010, and the quantity was diminished."

Dr. Carpenter's microscopic examination revealed casts of nearly all varieties except blood, and in very great abundance.

"A full dose of elaterium was administered, which operated fully. This was followed by the use of nitro-glycerine. One drop of a one per cent. solution, three times a day. The urine was examined chemically twice daily, and microscopically once a day, and at the end of two days only a trace of albumen could be detected, and it contained only a few casts.

"At the end of a week both albumen and casts had entirely disappeared, and at the end of two months the nitro-glycerine was discontinued entirely. Examination of the urine was repeated

at intervals from this time on, but with negative results.

"At the end of three months it was noted that the specific gravity was above 1.020, and that the quantity had considerably increased.

"It was then tested with Fehling's solution, and revealed distinct evidence that it contained sugar. From that date forward, nearly two years, the patient exhibited some of the ordinary phenomena of diabetes mellitus.

"The chief points of interest in this clinical history were: 1st. The well marked symptoms of kidney disease. 2nd. Their rapid disappearance under the influence of nitro-glycerine; and 3rd., the appearance of glycosuria, which has thus far remained permanent."

This is not the first time I have heard of the remarkable properties of nitro-glycerine in overcoming albuminuria; and "if we are all to have a similar happy result from its therapeutic employment, hereafter, it will be some compensation for its fearfully destructive power, hitherto, so often applied."

I would like very much to know if any member of the Society has had any experience in the use of nitro-glycerine.

That puerperal convulsions are hæmic in their nature is no longer a disputed point, although there may be a considerable amount of albumen in the urine without producing convulsions. We have often seen patients in whom an alarming œdema preceded parturition, and an examination of their urine increased our fears; and yet they have gone safely through their labor and returned to their normal condition.

But in many cases such severe organic changes have resulted from the condition of renal congestion from the uterine pressure as to lead to immediate or subsequent fatal effects. The blood drawn from these patients contains a large excess of urea, and there is a great vascular tension during the convulsive attacks which blood-letting often promptly relieves. One of my first cases of this kind occurred in a young primipara of about 18 years of age. The entire subsidence of all convulsive action after two bleed-

ings, and the safe delivery of the child in the interval, gave me great faith in the lancet from that day in such cases.

The greater tendency of primiparæ to this condition seems due to the structures, being less yielding and the pressure greater than in after pregnancies.

"Dr. Litzman found the urine to be albuminous in 37 of 131 pregnant or lately delivered females. Of the 37, 26 were primiparæ."

"Dr. Elliot detected the same state in 41 pregnant women out of 205, most of those in whom it was found being in their first pregnancy."

The changes produced in the kidney by this condition are from venous congestion and may be either temporary or permanent, according to its duration or degree, resulting in "excessive growth of epithelium, interstitial nucleation, fibrosis and granulation."

These conditions might exist in the non-parturient state without the convulsive symptoms, which are the more easily excited by the heightened nervous susceptibility of that state and the exhaustion following labor.

Even in fatal cases of puerperal convulsions, the change found in the kidneys, by no means correspond with the results, and proves that a less amount of uræmia can be borne in that condition than in the non-parturient.

Secondary pregnancies are more apt to lead to permanent organic changes and fatal results.

In twelve post-mortem examinations made by Dr. Braun of patients who had died from puerperal convulsions, or succeeding them, the kidneys were found in various stages of "venous congestion, such as mechanical causes would produce, succeeded by incomplete or well marked granular degeneration."

Interesting cases of this kind are mentioned by Drs. Simpson, Roberts and others, and are occurring in our practice now and then.

I have spoken incidentally of the treatment of most of the forms of albuminuria mentioned in this paper, and it leaves me nothing more to say as to remedies which must be applied according to the character and exigencies of



each case. That a great deal can be done for the relief of patients suffering from albuminuria, and the prolongation of many valuable lives, it has been my object to urge to-night. And I will close with the apostolic injunction, which is peculiarly fitted to our beneficent calling. "Therefore, my beloved brethren, be ye steadfast, immovable, always abounding in the work of the Lord, forasmuch as ye know that your labor is not in vain in the Lord."

### Society Reports.

#### BALTIMORE GYNÆCOLOGICAL AND OBSETRICAL SOCIETY.

REGULAR MEETING HELD APRIL 13, 1886.

The President, GEORGE W. MILTENBERGER, M.D., in the chair. WM. E. MOSELEY, M.D., Secretary.

#### DISCUSSION ON DR. W. P. CHUNN'S CASE OF OVIARTOMY WITH SUPRA-VAGINAL AMPUTATION OF THE UTERUS.\*

Dr. P. F. Mundé said he had operated twice for the removal of uterine fibromyomas. In the first case he was able to find the second ovary only after complete removal of the tumor. The ovary was adherent deep in Douglas' pouch and had to be ligated *in situ*. The stump was secured by long pins and constricted by a wire serre-noeud which came away on the sixteenth day.

The second case was diagnosticated to be a semi-solid ovarian cyst, but proved to be a myoma, attached to the uterus by a long pedicle. Palpation was obscured by œdema of the fat abdominal walls. The growth was adherent to all surrounding tissues, and in its removal both the mesentery and intestines were unavoidably torn. All rents were immediately sutured. In the after treatment of the case, a saline solution was transfused into the patient's blood. Secondary hæmorrhage ensued, when a second transfusion was resorted to and the

wound opened and bleeding points secured, but, in spite of all, death ensued after thirty-six hours.

In one case of double ovariectomy, with some adhesions, he had hesitated until the last moment about introducing a drainage tube, because there seemed to be no oozing whatever, but finally did so, and the next morning he removed some ten ounces of bloody serum through it, which discharge continued several days. He thought œdematous abdominal walls were not at all common in connection with ovarian cysts.

Dr. W. P. Chunn said he would like to state, in regard to his case, that he considered his patient as now fully recovered. The urinary fistula has entirely closed, the woman is up and about and rapidly gaining strength and flesh. Since the last meeting he had looked up the subject of the action of adhesions attaching the pedicle to the abdominal walls and found that his opinion, as expressed in his paper, that the adhesions would, in time, become stretched so as to allow the remaining portion of the uterus to resume its normal position, was in accord with the views of Dr. T. A. Emmet. Also, that the opinion advanced that, by the stretching of the adhesions, the fistula would become obliterated, had been verified.

Dr. T. A. Ashby remarked that there was one fact in connection with the case reported by Dr. Chunn which greatly interested him. He had reference to the occurrence of an ovarian tumor in a negro woman. He was convinced that ovarian tumors were of the rarest occurrence in the negro race. He had investigated the literature of ovariectomy very fully, and was surprised to find so few references to this fact. Neither Wells, Keith, nor Tait, have reported ovarian tumors among negro women, but this omission was satisfactorily accounted for on the ground that these operators seldom treated negro women. In the United States, and especially in the Southern portion, where a large negro population resided, one would expect to find reports of ovariectomies among these women, unless they were exempted from such pathological con-

\*See Maryland Medical Journal, March 27, 1886, page 420.

ditions by race peculiarities. Dr. Ashby said the only cases he could find in his researches through various authorities were, one case reported by Dr. W. L. Atlee, and the case reported by Dr. Chunn. He had no doubt other cases had been observed by operators, but he had not been able to find records of them. His attention was first called to this subject several years ago by a case which came under his observation through the courtesy of Dr. J. M. Hundley, of this city. The patient was a negro woman, between 40 and 45 years of age, whose abdomen contained a large cystic tumor, which was undoubtedly ovarian in its nature. The physical signs, history and condition of the patient were those of an ovarian cyst. The only facts which could render the diagnosis doubtful were the rare peculiarity in respect to ovarian cysts, and a failure to corroborate this opinion by an ovariectomy. An operation was urged, but declined by the patient. Subsequently the patient induced another physician to tap the cyst with a trocar, and she died very shortly thereafter. As the case passed from under Dr. Hundley's observation the name of the physician who performed paracentesis and the complete history of the case were not obtained. Dr. Ashby was satisfied as to the correctness of his diagnosis, and the only doubt which arose in his mind was created by the very rare occurrence of ovarian cysts in the African race. The patient referred to had about one-fourth white blood in her system, which may have some connection with the history of ovarian cyst.

*Dr. P. C. Williams* read the following paper:

#### AN UNUSUAL CASE OF POST-PARTUM HÆMORRHAGE.

Strictly speaking post-partum hæmorrhage is limited to the puerperal process attending or immediately succeeding third the stage of labor. In that sense, the case I am about briefly to report is incorrectly named, but it is difficult to designate it in other terms, and I have ventured to call it "An unusual case of

post-partum hæmorrhage." February 1st, 1886, Mrs. S., a strong, healthy, well-formed woman was confined with her first child. The labor presented no complication and was completed within a reasonable time under the influence of a moderate quantity of chloroform. The placenta was examined and was found to have come away entire, with but very slight loss of blood. There was an abundant flow of milk on the third day. The convalescence progressed perfectly until the fifth day, when I was sent for with great urgency. I was soon at the house and found the lady flooding violently, the bed filled with blood and the woman pulseless and prostrated to an alarming degree. The nurse had already given two teaspoonful doses of fluid extract of ergot and had applied ice freely to the abdomen. Placing my hand on the abdomen I found it filled with the womb, which was distended to the size of an eighth-month pregnancy. Recognizing the gravity of the position, I immediately administered hypodermically a drachm of fluid extract of ergot. I then inserted my hand and emptied the womb of the clots which had so largely distended it. As soon as it was emptied, I made constant, strong pressure upon the abdomen, and soon found that the ergot began to act and produce decided contractions of the womb. I then gave another hypodermic dose of ergot, which, with the continued pressure upon the abdomen, *maintained* the uterine contraction and the hæmorrhage was checked and never returned. The woman was frightfully reduced by the great loss of blood which she had experienced, but she soon began to rally and went on to a steady and complete restoration of health.

I was at great loss to explain the cause of this excessive and unexpected hæmorrhage. I had seen my patient at 10 o'clock that morning, when she was apparently perfectly well. At 1 o'clock that night was sent for and found the condition I have described. What could have produced the hæmorrhage? The woman was about 20 years old, had always enjoyed uninterrupted health, (I had known her since her birth) had had no trouble during her period of



pregnancy, her confinement was a little tedious but perfectly natural, there was very slight loss of blood during the labor, the placenta was expelled *entire*, and the progress of the case was unusually satisfactory until the eighth day, when the sudden change took place that produced the formidable hæmorrhage above described. Upon careful enquiry, I finally ascertained, through the lady's husband, that she was in the habit of putting herself to sleep by the inhalation of *chloroform liniment*, with which she saturated a handkerchief and applied it over her nose and mouth. This liniment consisted of two parts tinct. camphor and one part each of tinc. aconite and chloroform. She had inhaled this liniment night after night for several weeks before her confinement, and had gradually increased the quantity, until she used *eight to ten ounces every night*. The night in question she had used it with unusual freedom, and at 1 o'clock it had affected her so profoundly as to produce this alarming hæmorrhage. She was made to understand the great danger of her continuing the inhalation of the liniment and readily consented to abandon its use entirely. For a few nights I gave hypodermic doses of morphia to secure necessary sleep.

The dose of morphia was gradually diminished, and after *ten days* was wholly discontinued. This case interested me greatly:

I. It was the first of the sort that I had ever seen.

II. It proved the great power of the hypodermic use of ergot in controlling uterine hæmorrhage. In this case, as in others in which I have used it, its effect was almost instantaneous.

III. It is wonderful that anyone could habitually inhale a mixture containing so much aconite, viz., two ounces to the half-pint, and experience so little constitutional injury, as, both before and after the hæmorrhage referred to, her health has been perfectly good and has so continued until the present time.

*Dr. B. B. Browne* asked *Dr. Williams* if any remains of placenta or membranes were found in the clots passed by his patient, and cited a case reported by

*Dr. Coskery* before the Clinical Society. In this case examination of the placenta seemed to show that it came away entire, but on the inner surface of the uterus, which was removed post-mortem, there was quite a mass of placental tissue. *Dr. Browne* referred to a case of post partum hæmorrhage, which he had recently seen, in which the fluid extract of ergot, injected hypodermically, seemed to produce rapid contraction of the uterus, but, as an intra uterine injection of equal parts of vinegar and very hot water was used at the same time, it was impossible to tell which was the most active in checking the hæmorrhage.

*Dr. C. H. Riley* said he had seen one case somewhat similar to *Dr. Williams*. The patient, a primiparæ, got along very well for about a week following labor. At this time, to determine the exact position of the uterus, he introduced a sound with great care, but the examination was followed by profuse flooding. He tamponed the vagina, and left the tampon in for two days. There was no return of the hæmorrhage.

*Dr. G. Lane Taneyhill* stated that he had used *Bonjeau's* preparation of *Ergotine* hypodermically with admirable results in cases of post-partum hæmorrhage. Thirty grains of the ergotine were dissolved in 450 drops of glycerine, and 20 drops of this solution were injected. It was not necessary to repeat the injection.

*Dr. T. A. Ashby* remarked that whilst the treatment of post-partum hæmorrhage was being considered, he would say that he had had an experience with vinegar as a hæmostatic in post-partum hæmorrhage which confirmed his opinion in regard to its great value in cases where hæmorrhage could not be controlled with ergot and other agents. He then related a case of violent hæmorrhage coming on at the time of delivery from an atonic and fagged-out uterus. He gave ergot hypodermically twice, injected hot water into the uterus, used pressure and taxis, still the uterine contraction was unsatisfactory, and the loss of blood was kept up. He next called for vinegar. A half gallon or more was emptied into a basin, and with a Davidson's syringe, a stream

was quickly injected into the uterine cavity. Before the basin was emptied the uterus began to contract firmly. Hæmorrhage ceased promptly and did not return. Dr. Ashby believes that vinegar acts both as a hæmostatic and as an antiseptic. He favored the plan of using a syringe instead of a sponge, as recommended by the late Dr. Penrose. The long tube of the syringe could be carried well into the uterine cavity. There was less danger in doing this than from the introduction of the hand.

*Dr. George W. Miltenberger* said that Penrose and Wallace had stated that they considered vinegar, applied to the inner surface of the uterus, the most powerful hæmostatic in use. They had never known it to fail either in their own hands or in those of their students.

*Dr. L. E. Neale* related a case from his own practice (hospital) of secondary post-partum uterine hæmorrhage, occurring on the *ninth* puerperal day, and resulting fatally. The patient, an Irish woman, age 25 years, primipara, was delivered by low forceps operation, at the University Hospital, March 1885. The cervix and perineum were uninjured, the placenta came away entire, the third stage being normal. A mild attack of puerperal fever readily yielded to appropriate treatment. She was considered out of all danger and in excellent condition, when on the *ninth* puerperal day, in the absence of all attendants, a violent uterine hæmorrhage occurred and ceased spontaneously, leaving her moribund. She died on the following morning. Dr. N. considered the hæmorrhage in this case too profuse and sudden to be explained otherwise than by some form of atony of the uterus. He had never attended a case of severe or dangerous post-partum hæmorrhage, "*flooding*," in his own private practice, but, from what he had been taught and had clinically observed, he thought the immediate introduction of the hand in utero, (the obstetrician's hand whilst attending a case of labor should always be aseptic) with or without ice and squeezing the uterus between the hand without and the *first* within, the quickest and surest means of relief. He would also use ergot hypodermically.

*Dr. Williams* remarked that some years ago he reported before the Medical and Chirurgical Faculty of Maryland some cases in which he had used ergot hypodermically in post-partum hæmorrhage. In one case, he first passed ice within the uterine cavity, then his hand, and scratched the lining membrane, without producing any contractions. He then injected ergot into the thigh and as soon as possible reintroduced his hand into the uterus, when, almost immediately it contracted firmly. This was the case which suggested to him the hypodermic use of ergot. He considered the fluid extract of ergot a more reliable preparation than ergotine. He makes it a rule to instruct every woman, whom he is engaged to attend in labor, to have on hand chloroform and fluid extract of ergot and he always gives ergot at the end of the labor.

*Dr. H. P. C. Wilson* said he always followed the rule laid down by Dr. Williams in requesting his patients to have chloroform and fluid extract of ergot on hand before labor begins, but never gives ergot before the expulsion of the child, and only then when there is any indication for its use. We have, in the hand introduced into the uterus, the means of promptly arresting post-partum hæmorrhage, while other agents, to be used if necessary, have time to secure permanent contraction of the organ. He had confidence in the *hand* as a *urette*, in hot water and in ergot, in the above cases, but he did not approve of giving ergot after every case of labor, as it insured to the large majority of women, unnecessary suffering in excessive after pains, and he only used it in cases where there were indications of the occurrence of excessive hæmorrhage. He could recall one case where ergot by the mouth, rectum and hypodermically failed to control the hæmorrhage and when manipulation of the uterine cavity with the fingers was equally inefficient. The uterus would contract and expand again and again under these remedies, and the hæmorrhage, with each expansion, was frightful. This woman was saved, when almost moribund, by passing the hand into the uterus and, with long finger nails, raking the whole mu-



cous surface *thoroughly* for several minutes. She lost no more blood after this manipulation.

In another case of post-partum hæmorrhage, when ergot, and the hand and ice in the uterine cavity failed, he had saved the woman, when cold and pulseless, by by throwing very hot water into the uterus. In this case a pint or two of hot water would cause the uterus to contract and check the bleeding, but so soon as irrigation was stopped, the uterus would expand, and it was only after pulling the woman's hips over the edge of the bed, with a tub under her, and pumping in gallons of hot water, that he succeeded in producing permanent uterine contraction, and arresting the hæmorrhage. With the means now at our command, Dr. W. had come to the conclusion, that very few, if any should die of post-partum hæmorrhage.

*Dr. W. E. Moseley* had found intra-uterine injections of hot water a very certain method of checking hæmorrhage from the endometrium. So far it had never failed him. It must be used in large quantities and hot, not less than 115° or 120° F.

A FŒTUS ENVELOPED IN ITS AMNIOTIC SAC.

*Dr. G. L. Taneyhill* exhibited a five months' fœtus enveloped in its amniotic sac, with the placenta completely (in all its surface) attached to the sac, which was voided by Mrs. H. H., at 2 A. M. April 12th, in consequence of having taken a long walk, and on returning, slipped on an orange rind. She has bilateral laceration of the cervix, has had three children, one miscarriage and three premature births. No unusual symptoms supervened except profuse hæmorrhage which was checked by ice externally applied.

*Dr. L. E. Neale* said that Professor I. E. Atkinson had recently presented him with a specimen, now in the University of Maryland, identical with the one exhibited save that it was the result of a pregnancy probably a little further advanced. This was from a case of induced labor on account of advanced re-

nal disease and the method used by Dr. A., was Krause's, or the introduction of a bougee between the membranes and the uterine wall.

*Dr. T. A. Ashby* said the specimen presented by Dr. Taneyhill was an interesting one to him from the fact that he had never seen a fœtus completely enclosed in the amnion and expelled at so far advanced a period of pregnancy. He had often thought that this was the physiological method of delivery. He was led to this conclusion from an observation of parturition in the lower animals. He had observed the act of parturition in the mare, in the cow, in the sow, and in the ewe, and he was struck with the fact that the young of these animals are delivered into the external world, in the majority of cases, completely invested with the amnion. He witnessed some three or four years ago the act of parturition in some thirty or forty ewes and in very nearly every instance the young lamb was dropped with the amnion in-tact, and he also observed that where the amnion had been ruptured prior to delivery the act of parturition was more tedious. He did know whether his observation was the correct one, but if such be the fact, and if this be the design of nature in the lower animals, is not the modern obstetrician at fault in rupturing the amnion? Should not nature be left undisturbed in all cases of parturition unless there was some manifest purpose in an interference?

*Dr. G. W. Miltenberger* had had one case in which the fœtus, at full term, was born with the membranes entire. The child was born just before he entered the lying-in room and on turning the bed-clothes aside it was seen actively moving inside the unruptured membranes. The child did perfectly well.

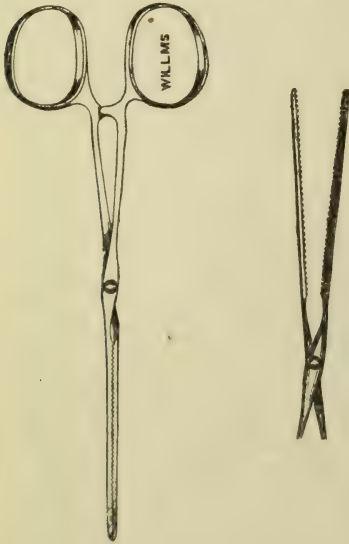
*Dr. L. E. Neale* thought the practical gist of Dr. Ashby's and similar remarks was the question, is the practice, recently advocated by Dr. Byford, of maintaining the membranes in-tact after complete dilation of the os uteri correct or not? Dr. Neale had brought this question before the Society at the last meeting, and all present, who spoke upon the matter, including Dr. Mundé, had ex-

pressed opinions opposed to Dr. Byford's plan.

*Dr. G. W. Miltenberger* said that after reading Dr. Byford's paper he had carried out his theories thoroughly for two months and was convinced that the membranes left in tact after full dilation of the os did no good, delayed the labor, and did not effect any dilation of the perineum, that part refusing to relax until after the head came down against it. The head when well down in the pelvic canal would fill it up so fully as to prevent any of the amniotic fluid from being forced down below it during the uterine contractions.

*Dr. P. C. Williams* thought leaving the membranes unruptured would only delay the labor, and that those cases in which the foetus came away with the membranes entire were cases of unusually tough membranes. As an example of tough membranes he stated that, in a case of shoulder presentation, in turning he was able to pass his hand up between the membranes and the uterine wall and the membranes ruptured only when he grasped the foetus.

A NEW COMPRESSION FORCEPS.



*Dr. Robert T. Wilson* exhibited forceps for the complete compression of the pedicle during removal of growths within the female urethra. The doctor said that the forceps were firm and se-

cure in their grasp, and their weight being so very slight, that, where hæmorrhage was feared, they could be left attached, in the canal, and the patient not at all troubled by their presence. The patient could urinate and move about without difficulty. Where they were used, it was not necessary to apply a hæmostatic. The forceps could be taken apart and thoroughly cleansed. They had been tested in several cases, and had given every satisfaction. They had been left attached twenty-four hours and the patient did not object at all to their presence. They could also be used for the compression of the pedicle of growths about the vulva, vagina and cervix.

*Dr. T. A. Ashby* remarked that Dr. Wilson's forceps were quite ingenious and could no doubt be used to good purpose. He had once had an experience with a caruncular growth in the urethra which proved to him that the hæmorrhage following the removal of these small growths could be very troublesome and alarming. The removal of a small growth, scarcely larger than a grain of wheat, located about five-eighths of an inch within the female urethra, was followed by the most annoying flow of blood he had ever experienced. Almost every effort to control it was successful for only a few hours, after which time the flow would return. Finally pressure with a large catheter accomplished the object desired, though this pressure failed in the early treatment of the case. Dr. Ashby said he had recently removed three small polypi from the cervix uteri of three patients. In these cases hæmorrhage was very profuse, but he had stopped it with Monsel's solution. In each of these cases the polypi were not larger than small filberts, yet they had occasioned profuse menorrhagia in each patient.

*Dr. H. P. C. Wilson* thought that the forceps of Dr. R. T. Wilson for arresting hæmorrhage in the urethra after the removal of polypi or caruncles, would prove to be a useful instrument. The bleeding after the removal of these little growths is sometimes very great and hard to arrest. With this instrument



the hæmorrhage is promptly and securely controlled and without much inconvenience to the patient. The use of Monsel's solution for arrest of hæmorrhage in the urethra is to be avoided, because it frequently fails in its object, and then the canal is so contracted and blocked with clots of iron and blood that we are cut off from the use of other styptics.

## MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

*Eighty-eighth Annual Meeting, held at Baltimore, April 27, 28, 29, and 30, 1886.*

(Specially Reported for the MARYLAND MEDICAL JOURNAL.)

### TUESDAY APRIL 27.—FIRST DAY.

The eighty-eighth annual session of the Medical and Chirurgical Faculty of Maryland was convened in the Hall of the Faculty, corner St. Paul and Saratoga Streets, on Tuesday, April 27th at 12.30 o'clock, P. M. The President, Dr. J. R. Quinan, presided over the meeting. After the reading of minutes of previous meetings, by Dr. G. Lane Taneyhill, the President read his annual address, to which he gave the following title:

WHAT VESTED RIGHTS DOES THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND NOW POSSESS UNDER ITS CHARTER TO REGULATE THE PRACTICE OF MEDICINE IN MARYLAND.

He began by saying, "before performing the *official* duty assigned me, let me discharge the *personal* one of thanking you for the honor you have conferred on me—an honor not less unsolicited than unexpected, and one, which the infirmities of age prompted me, as you well know, to decline, until assured that my worthy executive colleagues were ready to meet the duty of conducting the convention, for which my physical disability unfitted me. Having no claim on your suffrage, I accepted from you my present position, simply as a generous recognition (too generous, I fear) of the humble, but honest, and zealous efforts, which I have made, and shall ever make, to revive and aid in perpetuating the honorable annals of this venerable Society."

After a few general remarks commending the virtues, personal and professional, of the men who laid the foundation of the Faculty, Dr. Quinan proceeded to discuss the subject of his address. He presented the results of his examinations of the legal records of the State bearing upon the question under consideration. He remarked that as early as 1795 the medical men of Maryland saw the necessity of protecting themselves and the people from quackery. Their efforts finally culminated in the incorporation of the Faculty in 1798 under its existing charter.

"The preamble to this solemn compact between the State and the members of the corporation and their successors sets forth clearly the objects of its formation—'the promotion and dissemination of medical and chirurgical knowledge throughout the State,' and the 'prevention of its citizens from risking their lives in the hands of ignorant practitioners or pretenders to the healing art,' and by its fourth section it gives the Faculty, through their medical board of examiners, 'power to grant licenses to such medical and chirurgical gentlemen as they (either upon a full examination or upon the production of diplomas from some respectable college) may judge adequate to commence the practice of the medical and chirurgical arts, each person so obtaining a certificate to pay a sum not exceeding \$10, to be fixed on and ascertained by the Faculty;' and by its sixth section it provides that no person not already a practitioner of medicine or surgery shall be allowed to practice in either of said branches and receive payment for his services without having first obtained a license, certified as by this law directed, under the penalty of \$50 for each offense, to be recovered in the county court where he may reside by bill of presentment and indictment, one-half for use of the Faculty and the other for that of the informer.

"Now it is very evident, under these clauses, that the Legislature granted to this Faculty, in words as plain as English can make them, the sole and exclusive right to prevent any one, under a penalty, from practicing medicine or

surgery in this State without first obtaining a license from the corporate members of this Faculty and their successors. The charter under which this power was granted was not an ordinary statute, repealable at the pleasure of the Legislature, but, as I said, a solemn compact entered into with certain private individuals, by which the State guaranteed them certain corporative rights, powers, privileges and franchises forever, unless forfeited by abuse or voluntary abandonment by the coporators. Did they do either? Has any court ever convicted them of abusing these chartered powers or rights? For the purpose of answering this question I have examined all the statute-books of Maryland and the judicial decisions bearing on the matter from 1798 to the present day, and the result I will now proceed to state:

"The corporate members of the Medical and Chirurgical Faculty having met at Annapolis, June 3, 1799, and duly organized by the election of executive officers and boards of examiners and censors, proceeded at once under this charter to examine applicants and grant licenses to such as applied. In 1801 they secured a supplementary act to enforce, under the penalties, the same power. In 1816 they allowed the censors for the convenience of those who were graduates and could furnish by a diploma or examination satisfactory proof of fitness, to issue the license. In 1818 this act was repealed, and it was further enacted that non-residents of the State, but practicing within it, should be subject to the same requirements as residents. In 1821 persons or firms not licensed were disabled from suing or receiving compensation for professional services or medicine furnished. Provided that the defendant gives ten days' notice of his intention to dispute the claim, and persons duly lincensed are forbidden to form a partnership with those not licensed. This law was required to be given to the juries of the several courts. In 1838 an act was passed by the Legislature entitled 'An act to authorize Thompsonians or botanic physicians to charge and receive com-

pensation for their services and medicine,' while the body of the act reads, 'Be it enacted, that after the passage of this act it shall be lawful for each and every person being a citizen of this State to charge and receive compensation for their services and medicine in the same manner as physicians are now permitted to do.' I cite the whole of this absurd act to show the inconsistency between the title and the body of the act. One was for the benefit of a certain class of quacks styling themselves Thompsonians, and the other for the benefit of every white citizen of Maryland who chose to assume the role of doctor. The inside history of this legislative monstrosity is, I am told, that a bill of this kind for the benefit of these charlatans was gravely offered by some Solomon, and its absurdity was so apparent that some waggish member tacked on its present body the original title, and made a hybrid equal to Barnum's mermaid, composed of the head of a monkey and the body and tail of a fish, thinking thus to kill off its supporters, when to his surprise it passed in its present deformed shape. But be the origin what it may, it was palpably unconstitutional, because it violated the chartered rights of this Faculty in the exercise of its licensing power, and it defeated its own purposes, as the wild and murderous practice of the Thompsonians, who availed themselves of this act, worked so many grave-yard cures that there system soon followed its victims to that silent resting-place. In fine, it placed a razor in the hands of a maniac, who soon committed suicide. With the death of Thompsonianism it, of course, became inoperative and void, and is now only remembered as a grim legislative joke that cost the lives of a good many citizens. These are all the statutes on record relating to the Medical and Chirurgical Faculty, except one of 1861 and one of 1862, fixing the number of members necessary to call a meeting of the Faculty, which of course, has no bearing on the present question.

"From this review it is evident that from 1798 to the present there has been



no legislative act offered or passed to infringe upon or impair the power of this Faculty to require licenses throughout the State, (except the absurdity of 1838 now in operation) but, on the contrary, many acts secured by the efforts of this Faculty to confirm, enlarge and enforce this power, and I confess that as I had been led to infer from the opinions of others that our statute-books bristled with hostile legislation, I was more agreeably surprised at the result of my examination.

"But it may be asked, Did not the charters of the Medical College of Maryland and of the University impair this right? Did not the granting of diplomas to the alumni of these institutions render nugatory the licenses given by this Faculty? I answer, not in the least. The charters of the College and University were creations of the Legislature, subsequent to ours, and could not legally impair the obligations of a prior contract with this Faculty. This would violate the constitution of the United States and the bill of rights of this State, and knowing this they very wisely did not attempt it. Besides, it is well to remember that the Medical College of Maryland, and the Medical Department of the Maryland University, sprang from the loins of this Faculty, and always felt and showed a warm filial attachment to their parentage.

"The College and its conception and birth was accoucheured by members of this Faculty; its plan and organization proposed by a member of the Faculty and discussed by its members at a regular meeting where it received the warm approval of our second president, Dr. Philip Thomas, at the convention of 1802. To show the harmony of feeling that existed between the mother and child it is only necessary to examine the charter of the College, which provides in its third section that the members of the board of examiners of this Faculty are to constitute in perpetuum a part of the board of regents of the College, to whom was confided the whole governing power of the institution. In its fourteenth section it provides that every licentiate of this Faculty who has been practicing for five

years shall be entitled to a surgeon's certificate from the College; a licensed practitioner of this Faculty of ten years' standing to an M. B., degree, and a licensed practitioner of twenty years standing to the degree of M. D., without further examination or charge, except that of \$1 for registrar's fees.

"In its eighteenth section it provides that the Medical and Chirurgical Faculty of Maryland shall be considered the patrons and visitors, and the President of the Faculty, for the time being, the Chancellor of the College, and that the Medical Faculty of the latter shall report the progress of the College to this Faculty biennially. Surely this sufficiently proves that the corporation of the College intended no interference with the Faculty in requiring its license to practice from all, whether diplomated graduates of the College or not; nor was any such view entertained by the Professors of that institution, as they frequently, through the public press, notified all parties holding their diplomas that it was still obligatory on them to secure a license from this Faculty before being allowed to practice, the diploma not conferring *ipso facto* that right, but only affording *prima facie* evidence of professional qualifications.

"And when the Medical College of Maryland attained womanhood, and wished, by entering into close alliance with the faculties of law, of science and of divinity, to become a university, she did not attempt to assume any superiority over this Faculty in regard to this licensing power. Her Medical Faculty still recognized the fact that her own diplomas, like those of the College, had to receive the *imprimatur* of this Faculty before the holder could legally practice his art in the State. Nor did the Legislature question the continued existence of this right of the Medical and Chirurgical Faculty. On the contrary, in 1821 (ch. 217,) nine years after the charter of the Medical College and fourteen after that of the University, (during which period many diplomas have been granted by these schools) the Legislature passed the act, before referred to, recognizing the requirement of

the license, by attaching further penalties to the attempt to practice without it. If this be not enough to decide the point, we might cite the judicial opinion of the highest tribunal of this State, as given by Judge Buchanan on appeal of the Regents of the University for the restoration of their rights. The Court in sustaining the charter of the University goes into an elaborate discussion of the inviolability of chartered rights, and that the Legislature acted *ultra vires* when it attempted to set aside the Regents for a body of their own creation, and, hence, that their act was unconstitutional and void. All the reasoning of the Court applies with equal force to our own chartered rights, though the Court declared the Medical and Chirurgical Faculty was not a party before them and hence they were not called upon to discuss them. The counsel, however, for the trustees raised the point that the decision of the Court against the act of the Legislature of 1838, as unconstitutional and void because it conflicted with the chartered rights of the University, was equally good against the charters of the University and Medical College, as their right in granting diplomas impaired the chartered and older right of the Medical and Chirurgical Faculty in granting licenses to practice. To this the Court replied substantially that if it could be shown that the granting of diplomas impaired the right in question, it did not render the whole charter of the University null and void, but only such clauses as might conflict with the right of license of this Faculty, but the Court denied that the granting of diplomas superseded the necessity of a license, and further said, 'The charter of the University has no express provision dispensing with the necessity of a license to practice from the Board of Medical Examiners' of this Faculty, 'nor authorizing graduates of such institutions to practice without a license.'

"I am willing here to rest my case, but having read the legal records with the eyes of a layman, and not those of a jurist, I determined to get the additional judgment of those more familiar with

law on the subject of discussion, and therefore submit the question 'as to the right of persons to practice medicine and surgery in the the State of Maryland without having first obtained a license from the Medical and Chirurgical Faculty of said State' to the investigation of two gentlemen of the law of this city, whose standing and ability in their profession no one dares to doubt, and I now hold their written opinion, given after a full and deliberate examination of all the legislation and judicial decisions bearing on the question, and while I have taxed your patience too long to justify reading it at length, I am glad to be able to say that this legal opinion substantially confirms my own views, and in conclusion they declare that the act of 1838, in regard to Thompsonianism, confers no right except that expressed in the title, as is well settled by the law of this State, which decides beyond controversy that an act of Assembly is construed by its title, and excepted no one but those mentioned in title, and they are therefore of the opinion 'that no law has been passed dispensing with the requirement of a license by those desiring to practice medicine and surgery in this State of Maryland, as provided by the act of 1798, except Thompsonians or botanic physicians,' (who do not now exist to benefit by it) 'and that as to all others, that act of 1798 is to-day the law of the State, and can be enforced as such.' But I will submit the whole opinion to you, with a copy of my address. Let me in closing say that if after a full examination and deliberate discussion of this question you decide, as I do, that our chartered and vested right to require license from all who desire to practice medicine and surgery in this State exists to-day in all its integrity, unimpaired by legislation, unrevoked by judicial decision, as it did on the day it was granted, eighty-seven years ago, then I adjure you, by your regard for your own highest professional interests, by your regard for the honor, dignity and moral elevation of your calling, by your respect for the example of your brethren in other and adjoining States, who have successfully driven from our



borders the hordes of harpies who were fattening on the credulity of the people; by your regard for the ancient reputation of this venerable Faculty, and the restoration of that vigor of which it has been so long shorn by the Delilah of supineness and neglect; by your regard for the lives and sanitary welfare of the community; by each and 'all of these considerations I adjure you to boldly and manfully assert and enforce your vested rights, and at once and forever clean out the Augean stable of charlatanism and quackery, with their prescribers and indorsers of star-cures, liver-regulators, blood-purifiers, earth cures, *et id omne genus*, which shame the face of day in flaunting hand-bills on the street corners and in certain drug shops, whose proprietors show their gratitude for our patronage by prescribing over their counters the sugar-pellet nihilisms and more harmful nostrums that disgrace a decent pharmacy, and let us strip the mask from these lawless and unlicensed medical pretenders, begot by a foul union of unblushing effrontery, stolid ignorance and unsatiable greed. They are fast rendering our noble art in this State a stench in the nostrils of every lover of legitimate medicine."

Dr. Quinan closed his address in support of his position by reading the opinions of F. P. Stevens and Amos H. Evans, who have carefully examined the matter at his request.

After the reading of the President's address a resolution was offered by Dr. E. G. Waters, as follows:

"*Resolved*, That a committee of three, consisting of the present President as Chairman and two others whom he may select, be appointed to take into consideration all the legal questions growing out of the President's address in relation to unlicensed practitioners in Maryland, with power to act in all matters which may be necessary to bring said questions to a legal adjudication, provided said committee, before final action, report to the Medical and Chirurgical Faculty at a meeting called for the purpose."

This committee, announced later in the meeting, is composed of the President as

Chairman, and of Drs. E. G. Waters and B. B. Browne.

#### REPORTS OF OFFICERS AND COMMITTEES.

Under the call for reports the Corresponding Secretary, Dr. T. Barton Brune, read a report stating that he had conducted the correspondence of the Faculty and had performed other duties pertaining to his office to the best of his ability.

#### TREASURER'S REPORT.

Dr. W. F. A. Kemp, Treasurer, read his report, which stated at some length the financial status of the Faculty, and other facts pertaining to his office. The amount received by the Treasurer during the year was \$1,628, 29. The disbursements were \$1,769, 79. The assets of the Faculty are as follows: Building Fund account, \$192, 40; value of the Library (estimated) \$9,000; due from members \$340. The liabilities of the Faculty are \$141, 50.

During the year nine members had been added to the roll-call; losses by resignation were two; by death 5, and for non-payment of dues 4, making a total loss of 12.

#### REPORT OF THE EXECUTIVE COMMITTEE.

The report of this committee was read by the Chairman, Dr. T. S. Latimer. The report presented a statement of the work of the committee during the year, and referred to the change made in the location of the Library, which has resulted in an improvement of the condition of the Faculty. This change had been made at a considerable expense to the Faculty, but this expense has been in great measure met by the sub-leasing of the Hall to the various local societies. The report called attention to the fact that the Library Committee had arranged with Dr. Billings for the loan of books for the members of the Faculty from the Library of the Surgeon General's office, the Faculty assuming all responsibility for loss or damage, and for the safe return of books within the prescribed time. The members ordering

books are to pay expressage to and from Washington, and are limited in the use of them to the Faculty rooms.

#### REPORT OF THE LIBRARY COMMITTEE.

The report of this committee was presented by Dr. I. E. Atkinson, Chairman.

The report referred at length to the very decided progress in the important trust under its control. The lease of the present Library Rooms has placed the Library upon a footing that it has never before enjoyed.

"A very justifiable objection to entrust the Library with valuable donations heretofore has been the evident lack of security offered for the protection and preservation of books and other valuable material. By the change of location this objection has been met, as has been shown by the decided increase in the number and character of donations from members and others."

The number of volumes in the Library is 5,000; of these 830 were added during the past year.

The report then gave the names of the contributors to the Library and the number of volumes donated. Among these donations were a number of valuable and rare works. Sixty-three journals are now regularly received by the Library. The report laments the scarcity of funds entrusted to the committee for the use of the Library, and suggests that with \$800 it would be possible to place the Library upon a satisfactory footing, and to maintain a high standard of excellence.

The report closes with the following words:

"The responsibilities of your committee during the past year have been especially heavy on account of our removal into new quarters. Under existing circumstances it is difficult to believe that the year could have been brought to a successful close, had it not been for the unwearied attention of our Librarian, Dr. E. F. Cordell, whose services are now, as they have always been, a labor of love, and to whom the Faculty owes a debt of gratitude that can only be fully appreciated by those who have personal knowledge of his devotion."

#### REPORT OF PUBLICATION COMMITTEE.

This report was presented by Dr. G. Lane Taneyhill, Chairman. The committee had expended \$306.71 in publishing the annual volume of Transactions and in reprints of addresses. Copies of the Transactions were mailed to all the State Medical Societies and to many medical journals and societies throughout the world.

(To be continued.)

#### Correspondence.

NEW YORK CITY, April 27, 1886.  
*Editor Maryland Medical Journal.*

DEAR SIR—Will you kindly allow me space to correct an error in the report of the proceedings of the Baltimore Medical Association in your JOURNAL of April 17th. I am reported as saying that "I had removed the ovaries for Epilepsy," when it should have read "for Hystero-Epilepsy occurring at each menstrual epoch." This correction should have been made earlier, but being absent from home did not have an opportunity of reading the JOURNAL until yesterday, while visiting the library of the New York Academy of Medicine.

Very respectfully,  
J. H. SCARFF, M. D.

ERRATA.—Dr. R. H. P. Ellis wishes the following corrections made in his article, published in the MARYLAND MEDICAL JOURNAL, April 17th, 1886. On page 481, line 45, 3rd word, read "eructations" instead of "evacuations." In line 48 read "tympanites" for "tympanitis." The doses of calomel referred to were one-half grain instead of one grain and a half as stated.

The innominate artery was recently ligated by Mr. Bennet May, of London. The patient, who so far has done well, was a laborer suffering from a large subclavian aneurism. Dr. V. Mott first performed this operation, his patient living four weeks. Dr. Smyth, of New Orleans, is, we believe, the only surgeon who has successfully tied this artery.—*Medical Record.*



MARYLAND MEDICAL JOURNAL

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BALTIMORE, MAY 1, 1886.

Editorial.

ST. LOUIS MEETING OF THE AMERICAN MEDICAL ASSOCIATION.—At the present time the earnest attention of the profession in this country is concentrated upon the meeting of the American Medical Association, which is to convene in St. Louis on May 4th. At no time in the history of this organization will its deliberations be more carefully scrutinized than during the few days devoted to its work at St. Louis. From the organization of the Association until the meeting held at New Orleans in 1885, it had enjoyed to a marked degree the confidence, respect and coöperation of the profession in the United States. It had drawn to its support many of the ablest medical minds in the profession, and from year to year had enlisted a more wide-spread interest in its deliberations.

The meeting held in Washington, in 1884, was a fair illustration of the growing usefulness and popularity of the Association. As is often the case in the history of similarly organized bodies, there has not been wanting in the minds of a few friends of medical progress in this country, a conviction that this organization was not fulfilling its highest mission as a Scientific Association.

This fact has been frequently asserted, yet many of the fault-finders with the work of the Association have been willing to extend their influence and efforts in its behalf. Its defects were in a large

measure tolerated by a liberal spirit which desired to improve its condition. The conviction was likewise not wanting to many members of the Association that its conduct was too frequently guided by men whose conceptions of scientific work were hewed and squared by personal interests and motives rather than by that broad principle of good for the entire profession. Whilst in outward appearances the Association has gained in strength and influence, there has been concealed from view an under current of dissatisfaction with its management which was not encouraging to its true friends. When the invitation was extended to the International Medical Congress to meet in this country in 1887, by the Association at its Washington meeting, it was believed by many friends of the Association that this act would arouse a marked interest in its welfare. The Association Journal had then been successfully launched and its future was very propitious. The Washington meeting did much to inspire confidence in the future usefulness of the Association and in its official organ. The dying prayer of the distinguished surgeon, who passed into rest whilst the Association was in session, was accepted as an omen of good-will to all future deliberation of this body. The committee appointed by this meeting to invite the Congress to this Country in 1887, had every reason to believe that their instructions were final and conclusive. Their work, if not satisfactorily done, was, at least, discharged in good faith and in sincerity of purpose. Had it been accepted by the Association at its New Orleans meeting as final the benediction of good-will pronounced by the lamented Gross would, we believe, have been verified in the subsequent history of the Association. The episode at New Orleans has passed into history. Its results are now apparent to those who wish well of an organization, once so full of hopeful promise, now severed by hostile factions.

The blunder at New Orleans can never, in our opinion, be wholly repaired by future acts of the Association. Too many of the best minds in the profession

have been ostracised from its membership ever to bring back to its aid the full respect, confidence and coöperation it formerly enjoyed. The conduct of the ruling spirits which have guided the Association since the meeting in New Orleans has not been such as to encourage the belief that the meeting soon to be held in St. Louis will be able to correct any of the errors which resulted from that meeting. Those men who now guide the destinies of the Association have assumed an air of injured innocence towards those who manifested displeasure with their work at New Orleans, and it does not seem probable that any act which the St. Louis meeting may perform will rectify existing grievances. We should be glad to think differently but the signs in the sky do not indicate clear weather in that direction. In view of the approaching storm we would counsel a careful preparation for it. We would urge all who can to attend this meeting and to exercise an influence which aims to lull the violence of the storm and to calm the excitement of the disturbing elements. We should be glad to see a calm, judicial and conservative discussion of existing differences, and a fair and liberal concession from both parties to the points at issue. During the past year the battle has been fought with vigor, stubbornness and bitterness by both parties to the controversy. Many things have been said which were better left unsaid. The medical press has been outspoken and, at times, injudicious in its expressions of condemnation of both factions. We cannot see that these discussions have promoted any element of good feeling. The two sides have pulled farther and farther apart until the warfare of words, which should only concern the profession in the United States, has become a European scandal.

The American profession has been so belittled by this unnecessary wrangle that it is time to call a halt and go no further. One year yet remains before the Congress meets to settle our local jealousies and disputes. We ask those who go to St. Louis to consider all these facts and to use their influence in effect-

ing a reconciliation of these disturbances. We have nothing to suggest but the exercise of good sense, liberal views, and a conservative conduct.

### Medical Items.

*The Lancet* announces the death of Dr. Joseph Nowak, Professor of Hygiene in the University of Prague.

The B. & O. Railroad will issue round-trip tickets to delegates to the American Medical Association from Baltimore to St. Louis for \$15.

The University of Glasgow has resolved to confer the honorary degree of the LL.D. on Mr. Jonathan Hutchinson, the former editor of the *British Medical Journal*.

*The Lancet* says Mr. Savory, President of the Royal College of Surgeons, England, has been offered a knighthood, an honor which he declined to accept.

The Stanley Club, of Paris, France, on the 14th inst., gave a banquet to M. Pasteur, in recognition of his latest triumphs. The Hon. Robert McLane, formerly of this city, presided.

The Colleges of Physicians and Surgeons of Edinburgh and Glasgow have just decided to throw open to women their conjoint examinations and "triple qualification" in medicine, surgery, and midwifery.

The Association of American Medical Editors will meet in St. Louis on Monday evening, May 3, time and place to be announced. There will be a banquet, and each member is expected to contribute to the expenses.

The Corner-Stone of the New Building of the College of Physicians and Surgeons, of New York, at the corner of Tenth Avenue and Sixtieth Street, was laid on April 24th. Mr. Chauncey M. Depew delivered the oration.

The death of Professor Bouchardat, of Paris, a distinguished member of the French profession, is announced, at the age eighty. He was senior member of the French Academy of Medicine and Commander of the Legion of Honor.

Dr. Theodore Williams, having completed fifteen years' service as Physician to the Brompton Hospital for Consumption, has, on the recommendation of the medical committee been re-elected by the Committee of Management for a further term of five years.—*Lancet*.

Dr. W. S. Forbes has been elected to the chair of Anatomy and Surgery in the Jefferson Medical College of Philadelphia, made vacant by the recent resignation of Dr. W. H. Pancoast. There were a number of applicants for the position.



## Original Articles.

## REMARKS ON LANOLIN.\*

BY THOMAS G. MORTON, M.D., OF PHILADELPHIA.

Although the members may be familiar with the new substance, lanolin, introduced by Liebreich, I thought it might be interesting to exhibit a few specimens of this preparation from the wool of sheep. Those who have used it, have been much pleased with its employment in the preparation of ointments for external application. It can be readily rubbed into the skin and produces no irritation, and, therefore, would probably be valuable in massage. It is probable that substances combined with lanolin will be more readily absorbed than if prepared with other bases. One of the remarkable properties of lanolin is that it can be readily combined with water. I show you a specimen containing sixty per cent. of water.

I quote the following from the *American Journal of Pharmacy*, February, 1886:

"Under the name of lanolin, Prof. Liebreich introduced the fat obtained from sheep-wool. One of its properties is to take up more than its own weight of water. Unna states that cooling ointments should contain large quantities of water. Dieterich, with a view to determine the quantity of water taken up by different salve bases, experimented with twenty-one different bases at a temperature of 15° C., taking for each experiment 100 parts of the base. His results were as follows: Cosmoline took up 4 parts of water; lard, 15; benzoinated lard, 17; and lanolin, 105.

"Lanolin, as it now appears in the market, is a perfectly neutral base, and hence is not apt to decompose any medicament which might be added. Lasser experimented with it on 400 patients, and states that lanolin is readily absorbed by the skin, does not produce any ir-

ritation, and permeates the lower layers. Bachmann rubbed a ten per cent. iodide of potassium ointment, made with lanolin, into the skin for five minutes. After the lapse of half or three-quarters of an hour, iodine was detected in the urine. The elimination of the iodine by the urine continued for fourteen days after several applications of the ointment. Lanolin was used by the ancients, and is mentioned by Ovid, Herodot, Plinius, and Aristophanes."

I have received the following from Mr. McKelway, the druggist, who made the preparations shown to-night:

"All the published articles I have seen are very chary of any description of the detail of its manufacture. Liebreich patented his process in the United States in January, 1883, and the process patented by him is concisely stated as follows:

"He takes the suds from the washing of wool in the mills, submits it to the action of a centrifugal machine which separates the soapy, oily suds from the dirt associated therewith, decomposes the suds by an acid, whereby the acid and the saponifying alkali unite and the saponified wool-fat is separated, combined with about 100 per cent. of water; this is then thoroughly washed with cold water, then heated so as to separate the water and the wool-fat, and again combined with a definite proportion of water, and lanolin is the result.

"Or, he treats wool with alkaline water, producing his suds in that way, and then proceeding as I have already outlined.

"A much quicker and less complex way of making the article is to treat the wool directly with petroleum benzine; distil off the benzine, and the wool-fat remains; combine this with a proper proportion of water, and lanolin results. In his patent specifications, Liebreich speaks of this process, but says it is objectionable because of the difficulty of getting rid of the benzine odor. In the exceedingly short time I have had to prepare what I have prepared, this shorter process was the only one that I could use, and the samples I present were so made.

\*Read before the College of Physicians of Philadelphia, Stated Meeting, held April 7, 1886.

"Wm. M. Coates, Esq., the wool merchant, tells me that Merino wool, clipped without the sheep being washed, contains the enormous proportion of sixty per cent. of this fat. I enclose samples of the wool. If you will twist very tightly together a number of filaments of it, you will be able to collect the oil on your finger-nail. I also enclose some of the same fleece from which most, if not all, of the oil has been extracted with benzine.

"I send, also, a sample of the oil, labelled 'wool-fat;' and also a jar of lanolin, made by me by mixing this same wool-fat, 100 parts, with water, 30 parts (it is so labelled); and also a sample of lanolin imported for me by Messrs. Lehn & Fink, of New York.

"The cost price of the imported lanolin is now, in large quantities, \$1.00 per pound; a very little while ago it was \$2.00 per pound. I believe it will ultimately be about as cheap as lard.

"When it is considered that all wool averages about forty-five per cent. of its weight of this fat, that it has all to be removed before the wool can be manufactured into fabrics, that up to this time it has had no value, that the process for its extraction is not a very expensive one, and the lanolin is thirty per cent. water, I think you will be convinced that lanolin will certainly be as cheap as lard as soon as competition in methods of extraction and in supplying have an opportunity to affect its price.

"Billions of pounds of this wool-fat have hitherto been thrown away every year.

"If lanolin is what it is claimed to be therapeutically, a new and immense industry opens to the world."

The *Therapeutic Gazette* of March 15, 1886, speaks as follows of the practical uses of lanolin:

"From his investigations of the composition of the cholesterine fats found in keratinous tissue, Dr. Oscar Liebreich (*British Medical Journal*, Feb. 13, 1886) conjectures that the absorption in, to the skin would be best in the case of those fats which have their origin in the keratin-bearing substances, as hair, epi-

dermis, etc. The old theory that the skin was only oiled from glandular secretion, did not harmonize with these researches; and lanolin, upon his suggestion, is now being tested as to its efficacy in therapeutics as a new basis for salves and ointments. It is of importance to add other ingredients to make it more pliant, as it is a too sticky mass in itself to be employed alone; and from many trials which Dr. Liebreich has made with different substances—as vaseline, paraffine ointment, glycerine, oils, and fat—for this purpose, he has found the latter by far the best, as the others generally interfere with the absorbing qualities of lanolin. On exposure, the upper surface of lanolin, and all lanolin salves and ointments, becomes darkened, due to the evaporation of water and not to its decomposition."

Speaking with Dr. Leidy with reference to lanolin, he said that "the skin of the sheep has an enormous number of sebaceous glands, and that he was not surprised at the amount of fat taken from the wool. The usual way of making mercurial ointment—by rubbing up the mercury with mutton suet—is a rather troublesome and tedious proceeding. If lanolin is used, it can be made as perfectly in thirty or forty minutes as by the longer process. It is said that the 0.001 per cent. of bichloride of mercury with lanolin rubbed upon the skin, can be tasted in the mouth in thirty minutes.

[After the reading of the preceding paper:

Dr. Keen remarked: I have used lanolin in several instances during the last week or ten days. One case was that of a child, eight years of age, with an enlarged gland under the jaw, the size of an English walnut. I prescribed iodine, two grains to the drachm of lanolin. I saw the child a week ago, and the gland had almost entirely disappeared. This was a more rapid disappearance than I have ever seen from other iodine applications. This is the only case in which I have any results, although I have used it in a number of instances, and like it very well.



# THE OPHTHALMOSCOPE FOR THE GENERAL PRACTITIONER.\*

BY EDWARD JACKSON, M.D.,

Chief of the Eye Clinic in the Philadelphia Polyclinic.

The want of a form of ophthalmoscope specially suited to the needs of physicians who do not make the objective measurement of refraction an important part of their professional work, has been an obstacle to the more general practice of ophthalmoscopy. It is not my purpose this evening to announce the invention of an instrument to meet this want, but briefly to discuss and to incite to discussion of what should be the characteristics of such an instrument, that there may be better appreciation of a standard to guide practitioners in choosing among instruments now extant, and inventors among modifications that are possible in the future.

"The physician," says Hughlings Jackson, "is quite as much indebted to Helmholtz as the ophthalmologist." There is exaggeration in the statement; but under the exaggeration lies this truth: the physician's obligation to the inventor of the ophthalmoscope is great. How great we do not yet know; but some appreciation of it will be gained by a careful examination of such treatises as Gowers' *Medical Ophthalmoscopy*, or Dr. Wm. F. Norris' very condensed article on "Medical Ophthalmology," in Pepper's *System of Medicine*. The direct value of the ophthalmoscope in the consulting-room has been strenuously insisted on, and often illustrated. I will not dwell on it now; only let me remind you of the indirect importance of its use, as a means of training eye and brain for diagnosis in general. All schemes of education recognize the high value of some studies as means of mental development and discipline. For training the powers of observation and reasoning that must ever characterize the acute diagnostician, I think the practice of ophthalmoscopy is unequall-

ed. In it the student is incited to the certainty and exactness of microscopical research, yet must ever consider the personal diversities of patients. Then there is the wonderfully impressive character of the phenomena studied with the ophthalmoscope. In the words of Dr. Loring: "With it, is like walking into Nature's laboratory and 'seeing the Infinite in action,' since by its means we are enabled to look upon the only nerve in the whole body that can ever lie open to our inspection under physiological conditions, and to follow in a transparent membrane an isolated circulation from its entrance through the arteries to its exit through the veins. We are further enabled to study daily, or even hourly, morbid processes in each and every phase." These morbid processes are not only important in themselves; they have their close analogues in every organ, and in almost every tissue of the body. The value of this close study of pathology, of gaining insight, of getting into sympathy by close contact with natural processes, healthy and morbid, can hardly be overestimated. Well might the great German pathologist exploit the ophthalmoscope, and wish the methods of ophthalmology might be adopted in other branches of medicine. I submit the proposition that the more general use of the ophthalmoscope would tend toward such a desirable advance.

The instrument suited for this general use must have a few well chosen lenses: say, convex, 1, 2, 3, and 5 dioptrics; concave, 1, 2, 4, 6, and 10 dioptrics. Only these few are necessary. Higher degrees of hypermetropia are not common, and in such cases the fundus is readily examined either by using the accommodation, or by withdrawing a little from the eye under observation; while higher degrees of myopia are best studied by the indirect method. Unnecessary lenses, besides adding to the weight, complexity, and cost of the instrument, constitute a real and serious obstacle to its use. Often the ophthalmoscopist sees by glimpses. The position of the light, the ophthalmoscope and, the observer's eye, must be adjusted to the patient's position

\*Read before the College of Physicians, of Philadelphia, April 7, 1886.

before the first glimpse can be obtained, and whenever the patient moves the process of adjustment must be repeated. If the process of adjustment be prolonged by the necessity of running through a long series of lenses to select the proper one, it may be scarcely completed and the first glimpse obtained, before it has to be again repeated.

Now by long and frequent practice it becomes possible to make these adjustments very rapidly and automatically, and also to observe at a glance the condition of the parts under inspection, so that the ophthalmoscopist in constant practice finds the use of his instrument easy and satisfactory even though it be of a somewhat complicated pattern. But the student or practitioner who has not this perfect familiarity with the process, finds every additional difficulty of adjustment a very serious hindrance.

For this same reason it is highly important that the *lenses be most conveniently arranged*, so that the whole series is easily and quickly available when once the illumination of the fundus has been secured. They should be mounted in the Rekoss' disk used in most refraction ophthalmoscopes, or in slides such as I have proposed for the purpose (*Tran. Amer. Ophthal. Society*, 1885, p. 111.). The choice and the arrangement of the lenses are the especially weak points in the Liebreich ophthalmoscope, with which, probably, more medical men have essayed the practice of ophthalmoscopy than with any other one form of instrument. It may not be without interest to mention that one of the first attempts to improve on the Liebreich was made in this city over twenty years ago. At the instance of Dr. Chas. H. Thomas, through whose courtesy I am able to show this instrument, Queen & Co. modified the common Liebreich ophthalmoscope by mounting the mirror in a hard-rubber handle, and placing the lenses in a revolving disk behind the mirror. This is, of course, practically the Rekoss' disk, but in this case the name is inappropriate, for Dr. Thomas got the idea not from the work of the Dutch optician who seems to have immortalized himself by his addition to the ophthal-

moscope, but from the revolving diaphragm plate of his own microscope.

Another requirement is: *the aperture in the mirror should be small*, to lessen the circles of diffusion when ametropia cannot be exactly corrected, and especially to secure illumination of the fundus through the undilated pupil. Our popular American ophthalmoscopes have a mirror aperture of from three and a half to four millimetres. This is none too large in an instrument used for the accurate measurement of the errors of refraction, where it is desirable to emphasize rather than suppress the circles of diffusion. On the other hand many European modifiers of the ophthalmoscope have chosen smaller apertures, thereby reducing the value of their instrument as refraction ophthalmoscopes, but making it much easier to study the details of the fundus with them.

*The inclined, or tilting, mirror should be used.* Practical ophthalmoscopists find it more convenient and satisfactory, and to those less accustomed to the use of the instrument it is of much greater importance; less, perhaps, for its theoretical advantage of having the plane of the correcting lens perpendicular to the axis of vision, than for the greater ease in keeping the fundus properly illuminated. As a rule, the tilting mirror has, heretofore, been confined to the more costly and elaborate refraction ophthalmoscopes. There is one exception to this rule that merits notice. In 1882, Dr. Baumeister described a form of ophthalmoscope presenting no features of especial importance to the ophthalmic specialist, and hence, as yet, little known outside of Germany. Through the aid of Queen & Co., who have imported it, I am able to show a specimen of this form of instrument. Its special advantage is, as you see, a mirror tilting either way to an angle of twenty-five or thirty degrees. The aperture of the mirror is but two and a half millimetres. It has also a good series of seven lenses arranged in a Rekoss' disk. Moreover, this instrument is sold for but little more than the old Liebreich ophthalmoscope. This matter of cheapness is not unimportant



for an instrument that is to aid in generalizing the practice of ophthalmoscopy. Despite importance of thorough equipment for professional work, the cost of a good instrument keeps many from making its practical acquaintance. Its deterrent power is especially felt by the recent graduated, just when the hospital and dispensary opportunities, and comparative leisure in private practice, offer him the best and perhaps the only chance for gaining facility in the use of the instrument; and just when the insight it gives into vital processes would be of the greatest value.

But, as in Baumeister's ophthalmoscope, *cheapness should be secured by simplicity, never by poor workmanship.* In no instrument of diagnosis, not excepting the microscope, is perfect workmanship more important. There is none in the use of which mechanical imperfections are so serious a hindrance. And good construction includes more than the general strength and durability of the instrument. It includes thin lenses, freedom from reflections at the sight-hole, a spring catch to centre accurately the lens in use, mounting the lenses so that they can be readily cleaned and kept clean, and other details which might seem unimportant but which all help to determine the ease and satisfaction with which a given instrument may be used.

To recapitulate, the physician who does not undertake the correction of exceptional anomalies of refraction, needs an ophthalmoscope simply but well made, with a few well-chosen lenses, conveniently arranged, and a tilting mirror with a small central aperture or sight-hole. When the use of such an instrument becomes more or less familiar to well-trained physicians engaged in all branches of medical practice, we shall be able to appreciate better the debt of the physician to the inventor of the ophthalmoscope.

The heirs of the late William H. Vanderbilt have united in giving to the Trustees of the College of Physicians and Surgeons, of New York, the sum of \$250,000, to be expended in the erection and endowment of a clinic building. The site of the Vanderbilt Clinic will be opposite the Sloane Maternity.

## Society Reports.

### OBSTETRICAL SOCIETY OF PHILADELPHIA.

SPECIAL MEETING, APRIL 15TH, 1886.

The President, B. F. BAER in the chair.

*Dr. M. Price* reported two cases of

#### EMMETT'S BUTTON-HOLE OPERATION.

I desire to call the attention of the Society to a novel operation for the diagnosis and treatment of urethral and vesical diseases and accidents incident to parturition, devised and practiced by Dr. Emmett, of New York, for the past six years. In the last edition of his gynecology he treats the subject elaborately, and gives it, as in his judgment, the most rational treatment for prolapsus of the mucous and submucous tissues, urethrocele, lacerations of the urethra from dilatation or injuries in labor, gonorrheal inflammation, and abscess in the urethral wall.

I desire to report two cases of this operation, where no other treatment, in my judgment, would have been of the slightest benefit to the patients. The operation recommended by Dr. Emmett is what he designates as his "button-hole operation of the urethra," and may be performed either in the Sims's position, or in the lithotomy position. The operation consists in opening the urethra from three-quarters to one inch, midway between the urethral orifice and the neck of the bladder, thus giving ample room for inspection of the canal for any growth or condition requiring drainage or operative procedure. In those cases where the opening is made for diagnostic purposes simply, the opening may be closed with sutures, or be allowed to close in its own way.

Many cases of urethral irritation are wonderfully benefitted, and most of them entirely cured, simply by the free drainage it allows. The mucous membrane of the urethra and vagina are tacked together in these cases to prevent retraction. In the operation for urethre-

cele, the urethral opening is made through the pouch or dilated portion of the urethra, while a black tin bougie is held in the bladder. The opening is continued down into the mucous membrane, covering the sound and a sufficiently large piece of the mucous membrane of the vagina removed to insure the removal of the pouch. The mucous membrane is then taken under the sound and drawn through the button-hole opening, so as to obliterate the redundancy of mucous membrane. Sutures are then passed from the vaginal surface to the back-tin sound and back on the opposite side in the same position. All the sutures being thus introduced before cutting away the redundant mucous membrane held by a tenaculum in the hands of an assistant. This is to prevent the possibility of failing to incorporate the mucous membrane of the urethra in the sutures, and so fail to secure a perfect result, inasmuch as it is the mucous membrane, which, on account of its diseased condition, is giving the most trouble. This is also the operation performed for prolapse of the mucous membrane; its redundancy being pulled through the button-hole opening, back from the meatus, and there fastened. The redundancy is then cut away, instead of cauterizing it as in the past.

The first case is that of a lady, 32 years of age, the mother of four children. The last labor was very brief, as the woman was delivered with forceps in the hands of a medical man who had another engagement, and could not be delayed. This was four years ago. The woman, when she came into my hands, was suffering from a double laceration of the cervix, which was torn back to the vaginal vault, with laceration of the perineum back to the sphincter; and with a urethrocele that would have held two drachms of wine. There was also quite a protrusion of the mucous membrane of the urethra, what Emmett calls "hæmorrhoids of the urethra," from constant straining to pass urine. This woman had suffered constant tenesmus, or bearing down pains ever since her confinement with inability at times to go more than half an hour without passing

urine; at other times she was compelled to micturate every few moments, the urine passing with the greatest difficulty.

This was making great inroads upon her health. She had consulted quite a number of physicians, and was treated, from what I can understand, for "cystitis" and "ulceration of the womb." This, I believe, was the diagnosis of her trouble by the gentleman who had rendered her such efficient service at her delivery. The patient was operated on after the method of Dr. Emmet. An opening one and one-fourth inches in length on the vaginal surface, and three-fourths of an inch in the urethral wall was made, and the superfluous mucous membrane both from the urethrocele and from the mouth of the urethra drawn through the vaginal aperture, and the sutures put in before cutting away the redundancy of tissue. Seven sutures were applied, and a perfect result was obtained in one week. When the sutures were removed they were all found in a space not larger than the end of my finger in consequence of the contraction of the tissues. The woman passed her water ten hours after the operation, and continued to do so afterward without pain or discomfort. At the present time, three months after the operation, she says she is better than she has been at any other time since her last labor. I would also state that the perineum and cervix were also repaired at the same time. Silk-worm-gut sutures were used in this case.

The second case is one of great interest from a medico-legal point of view, as the cavity of the urethrocele was lined with a pus-secreting membrane. The patient, although under my care, was not examined until after the urethrocele, became very troublesome. I then learned that difficulty from this source, gradually growing worse, had been experienced for four years. These facts were not ascertained until the husband had repeatedly presented himself for treatment of a mild urethritis which always developed after sexual intercourse. His condition had been attributed to other than legitimate causes. After a considerable number of attacks, he began to inquire the cause of his affliction. Having been



asked the question as to "foreign relations," he stoutly denied any such cause, though he admitted that he had suffered from gonorrhœa early in life, but had been completely cured long before the time of his marriage, some fifteen years ago. He was then asked to have his wife present herself for examination at my office. I found her suffering from laceration of the cervix and a urethrocele. The urethrocele was exceedingly tender to pressure, and had the feel of a fibrous growth; no fluctuation could be detected upon light handling in examination. A pus cavity was suspected from the painful character of the tumor and the husband's condition. Repeated attacks of urethritis following sexual intercourse indicated an unusually irritating discharge from some source, and as the mucous surface of the vagina and cervix was in a healthy condition, and the discharges mild and unirritating, there could but be one rational explanation of the husband's condition, viz., a suppurating sacculated condition of the urethrocele, with periodical discharges of pus. Examination under ether fully confirmed the suspected pathological condition. The urethrocele was thickened, corrugated and filled with purulent ammoniacal urine. The patient was placed in Sim's position, and the operation was performed as detailed in the other case, except that the pus secreting membrane was carefully removed with the scissors, and the edges of the healthy mucous membrane were picked up with a tenaculum and the sutures of silk-worm-gut introduced as in the case before cited. A perfect result was obtained, removing all irritation of body and mind.

*Dr. Joseph Price* reported for *Dr. Barton Hirst* a cure of

first attempt at sexual intercourse with her husband, which caused her to suffer such acute pain that she almost fainted, she dates all her trouble. The sexual act was also followed by severe hæmorrhage which persisted for a month. The passage of feces and flatus per vulvam was at once noticed. Every repetition of the sexual act for the next two or three weeks was followed by renewed bleeding, and even at the present time she suffers severely during intercourse. The passage of the fecal matter through the vulva gradually increased in degree until the rectum was evacuated entirely through the vulva. There has been entire inability to retain flatus and feces.

*Examination:* The finger on entering the vulva passes at once into the rectum through a patulous opening of sufficient size to admit two fingers. Inspection shows a perfectly intact crescentic hymen of moderate thickness and rigidity having a small anterior opening. Immediately in front of its posterior attachment is an irregular transverse tear, an inch and a half in its longest diameter with thickened and everted edges, extending backwards and upwards for about one and a half inches, exposing to view the mucous membrane of the bowel. The vagina is small and has evidently never been entered. The operation proposed by *Dr. Joseph Price*, and done by him, March, 16, 1886, consisted in freshening the edges of the tear, partially loosening the hymen from its attachment, and using it as a flap to supply the deficiency of tissue. Shotted-silk-worm-gut tissue sutures were used, and the closure after the operation was complete, and resulted in perfect union. This form of injury to the vulva is very rare, for although sixteen cases\* of rup-

#### VULVO-RECTAL FISTULA FROM VIOLENCE DURING FIRST COITION.

The patient, a young woman of 22, presented herself at the gynecological clinic of the Philadelphia Dispensary, with the following history:

Previous to her marriage, which took place 18 months ago, she had been a perfectly healthy woman. From the

\*Paul F. Munde, 2 cases, *Boston Medical and Surgical Journal*, 1885.

Treiss, 2 cases, *Centrabl. f. Gynecologie*, 1885.

Chadwich, 1 case, *Boston Medical and Surgical Journal*.

Calles, 1 case, *London Medical Times and Gazette*.

Schroeder, 1 case, *Gynecology*, last edition.

Blumenthal, 1 case, *London Medical Times and Gazette*, 1860.

Thompson, 1 case, *Medical News*, 1885.

Ross, 1 case, *Canadian Medical and Surgical Journal*.

Massalitinew, 1 case, *Centrabl. f. Gynæk.*

Klinwächter, 1 case, *Wien Med. Ansdse*, 1885.

Cayley, 2 cases, *Indian Medical Gazette*, 1872.

Neuman, 1 case, *Lecture in Allgemein Hospital, Vienna*.

ture of the vagina have been reported during late years as occurring during coition, only one of them, recorded by Blumenthal, and operated on by Sir Spencer Wells at the Samaritan Hospital in 1860, bears any resemblance to the present case, which, from the careful analysis given it by Dr. Harris, is, without doubt, one of vulvo-rectal fistula. This form of fistula is much less common than the recto-vaginal. The case here reported is of special interest from the fact that the traumatism undoubtedly occurred during first coition; from the virginal condition of the hymen, and from the long time during which sexual relations were maintained under circumstances which must have been disagreeable to both husband and wife. There was no sign or suspicion of specific taint in either man or wife.

*Dr. Harris* remarked that he had seen and examined the patient, and was struck with her emaciation; inquired of her sister if she had not lost a great deal of flesh since her marriage. This brought out three photographs, all of which represented a short woman, of full habit, one of them having been taken two months before her marriage. The sister stated that the patient had no control over her evacuations from the rectum, and that she was being constantly soiled by their escape. But for the fact that the husband had been deprived of his prepuce in infancy, thereby rendering the penis callous, by the exposure of the glans to the air, it is hardly possible that he could have forced the organ through the flesh as he did. without so much personal suffering as to compel him to desist. Possibly, also, the tissues penetrated may have been less resisting than normal. As the arm of a fœtus has been known to perforate the rectum and protrude at the anus during labor, without laceration of the perineum, there must be in some women a much less than usual strength in the rectal wall. In considering the emaciation of this woman during the eighteen months of her married life, the question naturally arises was this condition due to the want of rectal alimentation; to the constant loss of fecal matter, or to the depressing

effects of her condition, weakening her appetite, and rendering her life miserable. The opening through the fossa navicularis into the rectum, corresponded exactly with some of the cases of congenital malformation which Dr. Harris had met with, and particularly with one in a large, stout primipara. In her, however, there was a slight anal sphincter, and except when afflicted with diarrhoea, she had control over her evacuations. The only case upon record which corresponds to this was operated upon by Sir Spencer Wells, in December, 1859, at the Samaritan Hospital.

*Dr. Price* remarked that eighteen gut sutures were introduced in closing the wound.

*Dr. Charles Meigs Wilson* exhibited a

#### FIBROID POLYPUS OF THE UTERUS.

This specimen was removed three weeks ago from the uterus of a patient with the following history:

For the past three years she has been flooding almost constantly. Her flow increased regularly at her catamenial periods, and at no time had it entirely ceased. She had suffered all the time agonizing pain, greatly increased during the menstrual period. The continued loss of blood had reduced her weight one-fourth, and the continued anemia of her nerve centres had produced characteristic effects. During all this time she had given her all the agents of the pharmacopœia vaunted for their efficacy in controlling uterine hæmorrhage, but the cavity of the uterus had never been explored, save in a desultory way with a sound. When first seen she was extremely anemic, emaciated, troubled with insomnia, and had a very irritable stomach. The uterus was dilated with the Ellwood Wilson cervical dilator. The growth, then readily seen, was grasped with a volsella and dragged as far as possible from the uterus; a curved crescent-shaped, probe-pointed bistoury was then made to sweep over the surface of the growth until it came in contact with the sessile attachment of the tumor which was severed with a sawing movement of the knife. Prior to the opera-



tion large doses of the fluid extract of ergot were given to the patient for forty-eight hours, in order to insure powerful contraction of the uterus after the tumor was removed. Immediately after the ablation of the growth, the cavity of the uterus was smeared with a solution of one part of Tait's iodine and two parts of pure carbolic acid. During the operation the patient lost half an ounce of blood. The removal of the tumor would undoubtedly have been accompanied by excessive hæmorrhage had not the precaution been taken to secure prompt uterine contraction by the previous administration of ergot. The patient made a happy recovery, has lost no blood at all since the operation, has gained in weight and improved in appetite. The case carries with it its own lessons. All the fruitless medication and the long period of suffering and distress might have been avoided had her medical attendants, at the beginning, dilated and explored the uterine cavity, removing the cause of the hæmorrhage instead of temporizing, and making use of the methods which, at best, in cases of continued hæmorrhage from the cavity of the uterus, are of a prophylactic nature. The polypus, when fresh, was four inches in length, two and a quarter in breadth, and one-and-three-quarters in thickness.

*Dr. Goodell* thought it was an error to expect hæmorrhage after the removal of uterine fibroids. *Velpeau* had removed a very large number of these tumors, and his method had been to cut them away by means of a knife, and yet he had hæmorrhage in two cases only. *Dr. Goodell* has removed very many of these tumors and has employed every method; he has never had any trouble from hæmorrhage. In Constantinople, while young in experience, and in consultation with another very young man, he saw a case in which auto-enucleation had commenced. The tumor was too large for removal by means of the *écraseur*, as the vagina was so filled up that the wire could not be got up to the base of the tumor. They concluded to cut off all they could get at, and then gave ergot. They next day another large slice was removed, and at the end of a week

they succeeded in directing the false pedicle, and all was safely removed without any hæmorrhage whatever. Since then he has ceased to fear hæmorrhage and thinks a danger is incurred by the use of ergot in causing contraction of the cervix uteri, and incarcerating the tumor. He removes many submucous tumours by dilating the cervix with his dilator, passing in the polypus forceps and accomplishing the diagnosis and removal at the same time, the latter being effected by twisting. When he has recourse to the *écraseur*, he now uses the finest piano-wire which is more efficient than the heavier and less likely to break. He first pushes the *écraseur* up to the fundus uteri with the wire bent over, and then coaxes the wire up, and in this way has little trouble in getting it around the base of the tumor. Before tightening the wire he removes traction from the tumor, and pushes up with the *écraseur*, so as to correct any inversion of the uterus that may have been caused in pulling the tumor down. Now when the wire is tightened, the tumor will be divided without fear of injuring the uterine tissue.

*Dr. Howard H. Kelly* said the choice of method in these cases should depend largely upon the individual peculiarity. *Chassaignac's* *écraseur* has rendered him good service in those polypi having broader bases of attachment, but when this is at the fundus and a large tumor chokes the vagina or cervix-uteri the difficulty of satisfactorily fixing the loop is very great. The chain added to the *écraseur* by *Marion Sims* is serviceable, but nothing will compare with the flexible, easily adjusted wire of a *Braxton-Hicks* *écraseur*. Where the pedicle was neither large nor dense he has had great satisfaction in the use of phosphor-bronze wire, which is much more easily manipulated than piano-wire. *Scanzoni's* plan of cutting the tumor off when the pedicle is long is excellent and safe. It goes without saying now that rigid antiseptic precautions should accompany any such operation.

*Dr. Parish* did not think there was much difference in the methods of different operations. He never gives ergot be-

fore any intra-uterine operation in which he wishes relaxation of the cervix. With the *écraseur* he uses wire and introduces it in the manner described by Dr. Goodell, and uses jeweller's pliers to manipulate the wire, pushing it up and around the tumor. He has no fears of sepsis if all the tumor be removed, but he takes the precaution of injecting a very hot solution of mercuric chloride after operating.

*Dr. Montgomery* has had free hæmorrhage after removing uterine fibroids by means of the *écraseur*. This hæmorrhage was so free in one case that hot water injections would not control it and Monsel's solution was applied with success. He, however, would not give ergot beforehand for fear of causing rigidity of the cervical tissues.

In one instance large piano-wire snapped several times on account of the firm, dense character of the pedicle, and he had recourse to cutting away portions of the tumor, the remainder being thrown off by natural action. The tumor had been adherent to the posterior wall of the uterus, and had been partially enucleated before operation. The patient was very weak, and septicemia and death resulted. In a case in which he used the wire *écraseur* a portion of the tumor was left; it was thrown off by auto-enucleation and was very offensive. The patient did not suffer from sepsis, but having wounded his own finger with a tenaculum in its removal, he was very sick in consequence. He thinks the spoon curette or saw would be the best instrument in the enucleation of fibroids.

*Dr. Goodell* carefully cleanses out the vagina before and after operation. He formerly used carbolic acid, but now prefers the mercuric chloride. He prefers the high note piano-wire which has never broken in his hands, as it cuts as well as crushes.

*Dr. W. S. Stewart* is glad to hear about the greater strength of the small piano wire as he has been using triple twisted wire, and has been much troubled by its breaking, so that he has given it up for the chain. He had mentioned his trouble to Gemrig, who recommended iron wire, which has been answering a

very good purpose. He much prefers Labarraque's solution of chlorinated soda as an antiseptic and disinfectant.

*Dr. Goodell* remarked that the finer piano-wire was not stronger, but was more efficient, as it cuts more easily through the tissues. Twisted wire will break more easily than single, because the strain on the different strands is unequal.

*Dr. Baer* agrees with Drs. Goodell and Parish as to the unadvisability of using ergot before operating. He has given up the *écraseur* on account of the difficulty attending the breaking of the wire. He is now in the habit of pulling down the tumor and removing it piecemeal. He uses vinegar if a styptic is needed.

*Dr. Wilson* has seen one death follow the use of the *écraseur*, and has had trouble in adjusting the wire; the liability of removing uterine tissue by the wire is a great danger. He thinks it better to drag the tumor down and cut it off in pieces. He feared hæmorrhage in this patient on account of the fearful loss of blood which she had already sustained. He considered prophylaxis the safer course.

(To be continued.)

## BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD APRIL 12, 1886..

The President, DR. W. F. A. KEMP, in the chair; J. M. HUNDLEY, M.D., Secretary

WATER INJECTED INTO THE RECTUM RETAINED AND ELIMINATED BY THE KIDNEYS.

*Dr. E. G. Waters* related the following case. He was called to see a man suffering with severe pain in the back about the region of the kidney. He could not make a satisfactory diagnosis, but left some medicine to quiet the pain, in a short while was sent for again, as the pain was as severe as before taking the medicine. He now ordered an enema of hot water, with the buttocks raised.



The water was thrown in the bowels as long as the patient could stand it, the first enema was ineffectual in either relieving the pain or unloading the bowel of feculent matter, and a second had to be used. It relieved the pain, but brought away very little feces, and the most curious part, is that very little of the water thrown into the bowel returned. He visited the patient the next morning and he (the patient) called his attention to the very large quantity of urine passed the over night, perhaps three or four pints. The man did not drink water the entire night. The doctor's solution of the matter, is, that the water retained in the bowel was absorbed and then passed off by the kidneys.

A CASE OF DIPHTHERITIC CROUP OR ŒDEMA OF GLOTTIS.

*Dr. Henry F. Hill* related the following case. He was called on Friday evening to see a boy, aged 12. On arriving he found that he had been suddenly seized with dyspnœa, had no fever, and the auscultation revealed nothing abnormal. The throat was normal to all appearances. Syrup of ipecac was ordered to be given him until it caused vomiting, which did him no good; perhaps the dyspnœa was increased. At his second visit he found him in about the same condition, and was at a loss to account for the symptoms. He naturally thought of spasmodic croup, œdema of glottis and diphtheritic croup; his not having any fever further complicated the case. He now ordered for him  $\frac{1}{10}$  gr. doses of calomel and a mustard plaster over the chest. On the next morning no improvement; bromide of potash and McMunn's elix. opii. were ordered, which relieved him somewhat, and he has slowly improved up to this time.

*Diagnosis.*—Either diphtheritic croup or œdema of glottis.

*Dr. S. T. Earle* said that at Bay-View they had a case presenting somewhat the same train of symptoms. The post-mortem revealed œdema of the glottis.

*Dr. J. W. Chambers* suggested the

idea that *Dr. Hill's* case was œdema of the glottis following a mild and undetected case of scarlatina, as we so often have kidney trouble after such cases. The doctor then related a case of a child suffering from diphtheritic croup, and for the relief of which he performed tracheotomy. The child was  $2\frac{1}{2}$  years old, and presented the usual symptoms of stenosis of the larynx. Tracheotomy was performed and the child progressively improved for six or eight hours. A student of medicine was left in charge of the case to see that the tube was thoroughly cleaned every hour, or oftener if necessary. The student explaining the manner of procedure to the father left. The man said he withdrew the tube every hour and washed it, but that is doubtful, for the tube was literally blocked with mucus and portions of false membrane. The child died in eighteen hours after operation. The doctor said this and some other cases proved to his mind that when we perform tracheotomy we should have an intelligent nurse or do without the tube altogether. He said that he heard *Dr. Tiffany* say that he never used the tube; but he liked the tube if he could have a good nurse; if not, he would cut out a ring or two of the trachea and do without the tube.

*Dr. E. G. Waters* said that *Dr. Hill's* patient might have been suffering from suppressed urticaria. He had had one or two such cases, the urticaria attacking the mucous membranes of the larynx, producing very alarming symptoms.

TRYPSIN AS SOLVENT FOR FALSE MEMBRANES.

*Dr. J. S. Ingle* asked if any members present had ever used *trypsin* for its solvent action on false membranes. He was now using it on a patient with diphtheria, and after nine or ten days' use the membrane had nearly disappeared. The mixture he was using on the patient gave out, and as there was the smallest possible particle of membrane left on the tonsil, he told her to use some of a previous mixture of iron, etc., thinking it would suffice, but it did not and the

trypsin had to be resorted to again, and it again caused the membranes to disappear. He thought the diphtheria due to defective plumbing and drainage in the house.

*Dr. G. H. Rohé* asked *Dr. Ingle* if the diphtheria could not be traced to contagion.

*Dr. J. S. Ingle* said he did not think it could.

*Dr. G. H. Rohé* said he did not believe that bad drainage &c., could produce diphtheria any more than it could cholera or typhoid fever; it may aggravate the trouble, and nothing more.

*Dr. Henry F. Hill* asked *Dr. Rohé* if scarlatina could only be induced by contagion.

*Dr. G. H. Rohé* said he thought the same rule would hold good with it, as with diphtheria.

#### CONSTIPATION LASTING FOURTEEN DAYS.

*Dr. J. W. C. Cuddy* related the following case: He was called to see an old man who had had a fall; no bones were broken, but he suffered very much from shock to his nervous system, and was more or less unconscious. Brandy and ammonia were given for the prostrated condition, and as his bowels had not been moved for a week, a bottle of citrate of magnesia was ordered to be given him. At the next visit, as the magnesia had not acted, he ordered c. c. pills, and if they did not act, to give repeated doses of salts. He went on in this way from day to day taking various remedies, eating and sleeping well, without fever, and pulse 88. It was now fourteen days, and his bowels had not been moved. An enema was now given, and it moved his bowels freely, since which time they have been regular. The doctor thought it strange that one should remain so long constipated without great deterioration in health, appetite &c.

*Dr. Henry F. Hill* said he called to mind a negro girl that often went two or three weeks without an action from the bowels, and attended to her duties in the meantime.

*Dr. John Dickson* read a paper on

#### ALBUMINURIA.\*

##### DISCUSSION.

*Dr. J. E. Gibbons* said that *Dr. Dickson's* paper was most interesting to him, as he now had a case of rheumatism complicated with albuminuria. He would like to know of the doctor how he used the salicylate of soda and iron referred to in his remarks.

*Dr. John Dickson* said the iron was only used where there was diphtheria, and he gave the salicylate sodo in 20 grain doses every four hours.

*Dr. R. H. P. Ellis* said he thought if we were to examine the urine of most febrile patients we would very often find albumen. The mere fact of albumen being in the urine amounts to nothing; with convalescence it may disappear and leave behind no structural lesion of the kidney. *Dr. Ellis* thought it strange we did not have albumen in the urine at all times.

*Dr. J. W. C. Cuddy* said he always looked well into every case whenever albumen was found in the urine, and it to his mind always meant some derangement health; some organ was not doing properly its work, it might be kidney or liver.

*Dr. J. T. Smith* said that patients seldom enjoyed perfect health when albumen was found in their urine. If it be intermitted, and exist only for a short while, the person may feel no bad effect therefrom, but if it continues we may be sure there is something radically wrong, and deserving of more than a passing notice. He said in every case of albuminuria the microscope should be used; if no tube casts are found, he would prognosticate favorably upon the ultimate result.

*Dr. J. W. Chambers* said that albuminuria was a symptom just as cough is a symptom of lung or throat trouble. He thought it a hard matter to go through life without at some time having albumen in the urine. Albuminuria may mean much or little. If one has albumen in the urine from slight exercise,

\*See MARYLAND MEDICAL JOURNAL, May 1, 1886.



over-eating, &c., he feared he would die of Bright's disease. A healthy kidney should never show albumen in the urine.

*Dr. E. G. Waters* said that two points made by *Dr. Dickson* were of much interest to him:

1st.—The diagnosis between croup and diphtheria. In diphtheria the urine contains albumen; in croup it does not.

2nd.—The treatment of dropsy, &c., by baths and purgatives.

He has seen much good done by baths, especially vapor baths. He believes albumen in the urine common after a hearty meal of eggs.

## MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

*Eighty-eighth Annual Meeting, held at Baltimore,  
April 27, 28, 29, and 30, 1886.*

(Specially Reported for the MARYLAND MEDICAL  
JOURNAL.)

(Continued from last issue.)

### WEDNESDAY APRIL 28.—SECOND DAY.

The Faculty was called to order at 12 M. by the President. After the reading of the minutes, *The Annual Address* was delivered by *Col. George E. Waring*, of Newport, R. I., who announced as the subject of his remarks:

#### THE REMOVAL AND DESTRUCTION OF ORGANIC WASTES.

*Col. Waring* began his subject by referring to the influence of organic waste on the health of communities. He attributed the disease of civilization to the conditions resulting from bad sewerage and argued that the prevention of these diseases was to be secured by the removal of the cause. He laid down as a rule that every organic substance when its usefulness has been imparted and its stability threatened, should be immediately removed from the household or community to a distance. Being once

removed their safety was assured. The subsequent disposal should be secured by its destruction under conditions which will not favor the pernicious results attendant on restricted and aborted decomposition. The object to be sought in regard to the disposal of municipal organic wastes is to secure their prompt and complete removal and their rapid resolution into inorganic matter.

#### REPORT OF SECTION ON SURGERY.

*Dr. Randolph Winslow* presented a supplementary report from this section. He limited his remarks to the consideration of "The Treatment of Penetrating Wounds of the Abdomen," and "The Treatment of Intestinal Obstruction," also giving a passing notice to some recent "Operations for the Relief of Pyloric Stenosis" and to some cases of Resection of Portions of the Large and Small Intestine.

After referring to the increasing interest of surgeons in the consideration of the treatment of this class of injuries, and the growing belief that better results ought to be obtained than was usual under the old lines of treatment, *Dr. Winslow* referred to the case on which *Dr. W. T. Bull*, of New York, performed laparotomy for gunshot wound of the abdomen and sutured seven holes in the intestines, the patient making a good recovery. During the past twelve months several additional cases have been operated on, and notably that upon which Surgeon-General *J. B. Hamilton*, of Washington, performed laparotomy and sutured thirteen holes in the intestines. On the seventh day feces passed per anum, on the twelfth, the ball was voided with the stools and the patient made a good recovery. Seven cases of recovery after laparotomy were mentioned as having been recorded. The experience of *Dr. E. Andrews*, of Chicago, was alluded to as novel and suggestive. Two patients who were shot in the region of the stomach, recovered without an operation and without experiencing any difficulty. Another case upon which he performed laparotomy, no wound of any viscus was found,

the abdominal incision was closed and the patient recovered. Dr. Dennis, of New York, in a stab wound of the abdomen, performed laparotomy, made a careful examination of all the viscera, and found no injury whatever. The patient recovered. The last cases are mentioned in order to show the need there is of great caution in opening the abdomen, lest unnecessary operations be performed. Several unsuccessful laparotomies for penetrating wounds were also related.

In conclusion, after giving the views of different eminent American surgeons, for and against laparotomy, Dr. Winslow said, "In summarising the prevailing professional opinion in regard to the treatment of penetrating abdominal wounds, it appears that there is an almost unanimous consent to the propriety of performing laparotomy when there is reason to believe that serious injury to any of the hollow viscera has occurred, or that hæmorrhage is taking place, but there are certain cases in which the nature of the lesions is doubtful, and it is in such cases that diversity of opinion exists. For my part I am more firmly convinced than ever that where there is a strong probability that serious intestinal injuries have been received, a laparotomy ought to be performed, but I think a certain amount of conservatism ought to be indulged in, especially in wounds from bullets of small size or from stab wounds, many of which either do not penetrate the viscera at all, or produce such small holes as to do no material harm."

In discussing the subject of "Treatment of Intestinal Obstruction," Dr. Winslow said :

"The causes of obstruction of the bowels are many, but the most frequent are constrictions of some portion of the tube by internal herniæ, bands of new formation or adhesions, or from volvulus and intussusception. In many cases an accurate diagnosis cannot be arrived at, hence arises the confusion in regard to the line of treatment to be pursued. Whilst surgeons are not agreed as to whether these cases are best treated by medical or surgical means, there is a

growing tendency to resort to laparotomy. Mr. Jonathan Hutchinson, of London, is an earnest opponent of operative treatment, and recommends what he denominates abdominal taxis, which consists of certain manipulations of the abdomen, the inversion of the patient, shaking him vigorously, tossing him in a blanket, etc., under an anæsthetic. He reports a number of patients treated successfully in this manner."

Mr. Treves and others recommend laparotomy as soon as a reasonable diagnosis can be made out, and in doubtful cases also. Treves says "it seems to him to be tampering with life to waste time over the administration of metallic mercury, and enemata of tobacco and the like. To thrust an aspirator into the abdomen is a stab in the dark. Massage or abdominal taxis has its advocates, but the procedure is at best a blind one. The manipulation of the abdomen may, by a rare combination of circumstances, reduce the secured loop, but it is as likely to aggravate its condition and to produce a perforation in a segment of intestine that is approaching gangrene and that needs the tenderest handling." Dr. Winslow expressed his personal opinion that "a case of intestinal obstruction should first have the benefit of rational medical treatment, first by laxatives to overcome a possibly obstinate constipation, then by copious enemata with the patient in the genupectoral or completely inverted position; if the symptoms are not severe belladonna or opium may be administered in large doses, but if the patient presents urgent symptoms, severe pain, obstipation, constant vomiting, especially if the character of the latter becomes feculent, no time is to be lost, the abdomen should be opened." Acting upon these views on December 8, 1885, Dr. Winslow performed laparotomy on a young woman, who for seven days had presented symptoms of intestinal obstruction, as denoted by severe pain, obstinate constipation, and constant vomiting which at last became feculent. Medicine and enemata having failed to give relief, the abdomen was opened, and a loop of ileum was found adherent to pelvis between rectum and uterus for



a space of six inches, with complete arrest of its functions. The adhesions were broken up, and the loop of intestine released. The patient made a speedy and complete recovery and remains so to this day. Two other cases have also been operated on in this city during the past few months, one successfully and the other unsuccessful.

*Dr. J. W. Chambers* presented a paper entitled.

#### REMOVAL OF ENLARGED AND SUPPURATING GLANDS OF THE NECK.

The object of this paper was to discuss the proper treatment of these glands. These large lymphatic glands are not at all infrequent. They occur at all ages, but are observed more frequently among children, probably because the causes which produce them are more constant. *Dr. Chambers* did not attempt to differentiate between those due to scrofula or tubercle, but treated of them as one and the same. "Clinically speaking they are malignant glands and as such, should be treated. As surgeons would argue alike in reference to tuberculosis of the testicle, I venture to say there would be but one general expression of opinion for the removal of diseased organs, unless general infection had already taken place. The same general rules of surgery and common sense should be assiduously applied to tubercular glands of the neck as are applied to the testicle, unless some reasonable objection can be offered."

"The surgical fear of deep seated cellulitis of the neck has lost its terrors under the influence of antiseptic surgery; and with anæsthetics and deliberate dissection with the handle of the knife and fingers, bleeding and shock are not now prominent dangers, and that we are only limited in the extent to which we shall attempt the removal of these glands by anatomical considerations."

*Dr. Chambers* then related the histories of four cases treated by the removal of deep seated glands of the neck. In each case there was only transient rise of temperature and no signs of septic absorption.

The next paper read before the section was presented by *Dr. J. H. Branham*. It was entitled

#### CLINICAL NOTES ON GENITO-URINARY SURGERY, FROM BAY-VIEW HOSPITAL.

The paper was devoted to a consideration of the history of five cases which had been selected from a large number because they presented special points to which the author wished to call attention. Cases one and three were related to show how difficult it is to differentiate between the hard and soft chancre, and cases two, three and four were related to show the relative value of the dorsal incision and circumcision in the treatment of concealed sores. The fifth case was related to illustrate the good effects of internal urethrotomy in the membranous urethra, it still being a question as to the good results of this operation as compared with external urethrotomy in these cases.

#### ELECTION OF MEMBERS.

Upon the recommendation of the Board of Examiners for the Eastern and Western Shores the following members were elected: *Drs. W. T. Cathell, J. M. Magraw, W. E. Magruder, Amanda Taylor-Norris, C. C. Shippen, W. H. Welch, T. P. McCormick, and J. K. H. Jacobs.*

*Dr. Amanda Taylor-Norris* is the first female physician elected to membership of the Faculty. *Dr. Taylor-Norris* is a graduate of the Woman's Medical College of Philadelphia. She is a native of Maryland and practices her profession with success in this city. She is now Lecturer on Mat. Med. and Therapeutics in the Woman's Medical College of Baltimore.

#### THIRD DAY.—THURSDAY, APRIL 29.

The Faculty renewed its sessions at 12 o'clock M., the President in the chair.

The report of the

SECTION ON OBSTETRICS AND GYNÆCOLOGY was next called for.

The first paper was read by Dr. B. B. Browne, and was entitled "The Curette as a Diagnostic and Therapeutic Agent in Obstetrics and Gynecology."

Dr. Robert T. Wilson exhibited an instrument designed to be used as "A Temporary Clamp, Especially in Operation of Ovariectomy, Oophorectomy, and Trait's Operation."

Dr. G. W. Miltenberger read an able and elaborate paper on "Eclampsia" which enlisted earnest attention and interest, and was regarded by those who heard it read as a most clear and valuable study of the subject.

The next paper was read by Dr. D. W. Cathell. It was entitled "A Case of Labor Complicated by Uterine Fibroids."

Dr. John Morris reported "A Case of Eclampsia." The discussion following the reading of these papers consumed the remainder of the time devoted to the session.

(To be continued.)

#### OFFICERS AND COMMITTEES OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND FOR 1886-7.

At the recent meeting of the Medical and Chirurgical Faculty of Maryland, the following officers were elected to serve for the ensuing year: President, Dr. George W. Miltenberger; vice-presidents, Dr. Thomas Opie, Dr. Richard Gundry; recording secretary, Dr. G. Lane Taneyhill; assistant secretary, Dr. Robert T. Wilson; corresponding secretary, Dr. T. Barton Brune; reporting secretary, Dr. Richard H. Thomas; treasurer, Dr. W. Fred. A. Kemp; executive committee, Dr. P. C. Williams, Dr. James Carey Thomas, Dr. H. P. C. Wilson, Dr. John R. Quinan, Dr. J. E. Michael. Examining board for Western Shore: Dr. C. H. Jones, Dr. F. Donaldson, Sr., Dr. S. C. Chew, Dr. T. B. Evans, Dr. I. E. Atkinson, Dr. T. A. Ashby, Dr. A. Friedenwald. Examining board for Eastern Shore: Dr. S. T. Earle, Dr. B. W. Goldsborough, Dr. A. H. Bayley, Dr. James Bordley, Dr. G. T. Atkinson.

The President made the following appointments:

*Committee on Library.*—Drs. I. E. Atkinson, B. B. Browne, T. B. Brune, G. L. Taneyhill, Jno. N. Mackenzie.

*Committee on Publication.*—Drs. G. L. Taneyhill, W. F. A. Kemp, A. B. Arnold, Wm. A. Moale, H. H. Biedler.

*Committee on Memoirs.*—Drs. Edmund G. Waters, E. F. Cordell, Chris. Johnston, Jr., J. F. Monmonier, John Morris.

*Committee on Ethics.*—Drs. P. C. Williams, Samuel C. Chew, J. C. Thomas, F. E. Chatard, Jr., Chas. H. Ohr.

*Section on Surgery.*—Drs. J. E. Michael, W. B. Platt, Oscar J. Coskery, Jno. W. Chambers, T. W. Simmons.

*Section on Practice.*—Drs. Samuel C. Chew, Jno. S. Lynch, W. D. Booker, W. Stump Forwood, James Bordley.

*Section on Obstetrics and Gynecology.*—Drs. Wilmer Brinton, B. B. Browne, R. T. Wilson, Aug. F. Eick, A. H. Bayley.

*Section on Mat. Med. and Therap.*—Drs. I. E. Atkinson, Claude Van Bibber, Wm. Green, R. H. Thomas, Geo. H. Hocking.

*Section on Sanitary Science.*—Drs. E. G. Waters, W. C. Van Bibber, Wm. Lee, Jackson Piper, F. E. Chartard, Jr.

*Section on Anatomy, Physiology and Pathology.*—Drs. R. Winslow, Joseph T. Smith, W. T. Councilman, Thos. S. Latimer, G. E. Porter.

*Section on Psychology and Medical Jurisprudence.*—Drs. A. B. Arnold, Jno. S. Conrad, Chas. G. Hill, G. L. Taneyhill, R. Gundry.

*Section on Microscopy Micro-Chemistry and Special Analysis.*—Drs. L. M. Eastman, L. H. Steiner, Adolph. G. Hoen, T. B. Brune, Christ. Johnston, Sr.

*Section on Ophthalmology, Otology and Laryngology.*—Drs. J. J. Chisolm, Jno. N. Mackenzie, H. C. McSherry, Samuel Theobald, Samuel Johnston.

*Curator.*—Dr. Joseph T. Smith.

*Delegates to American Medical Association.*—Drs. J. E. M. Chamberlain, G. T. Atkinson, A. B. Arnold, B. R. Benson, J. J. Chisolm, George F. Corse, Jno. S. Lynch, Chas. H. Diller, Jno. Barron, B. W. Goldsborough, Jno. Morris, J. H. Grimes, J. F. Perkins, J. Lee McComas, A. B. Lyman, Jas. S. Martin, Arthur Williams, Chas. G. Macgill, Jno. M. Williams, Jno. W. Chambers.

*Alternates.*—W. S. Maxwell, J. H. Prentiss.

*Delegate to Pennsylvania State Medical Society.*—Dr. Jno. Barron.

*Delegate to Virginia Medical Society.*—Dr. Jno. S. Conrad.

*Delegates to Alabama.*—Drs. P. H. Reiche, W. J. Jones.

*Delegate to West Virginia.*—Dr. George B. Reynolds.

**PRIORITY IN SCIENTIFIC DISCOVERY.**—We are constantly reminded, in contemplating the history of medicine in this country, that there are many persons in the profession who are still in ignorance as to what really does constitute a valid title to priority in scientific discovery. Now, for the benefit of such persons, we would observe that, just as the Patent-Office in affairs secular, confers an inalienable right to the proprietorship of an invention, so in affairs professional the prior publication in a reputable scientific journal of a discovery or improvement entitles the publisher of such article, according to the universal usage of civilized nations, to full and absolute priority. Only among savages and barbarians can the credit be denied such a person without exciting the contempt of the community.—*N. Y. Med. Journal.*



## MARYLAND MEDICAL JOURNAL

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BALTIMORE, MAY 8, 1886.

**Editorial.**

**AMPUTATION OF THE PREGNANT UTERUS.**—As statistics accumulate the results of the Porro operation and its modifications, which have for their end the amputation of the pregnant uterus, are shown to be very encouraging, and by far more successful than the old classical Cæsarian section. The superior advantages of the Porro operation seem to commend themselves to those surgeons who have had experience with both methods. As an illustration of this fact we have before us the experience of Mr. Lawson Tait (*British Medical Journal*, April 10, 1886, page 694.) whose well-known skill in abdominal surgery is recognized throughout the civilized world. Mr. Tait read a paper on this subject before the meeting of the British Gynecological Society, held March 10th, 1886, in which he states that his experience in meddling with the pregnant uterus by abdominal section consisted of five cases: three of these were the ordinary Cæsarian section, and two were Porro's operation. Of the three Cæsarian sections all the mothers died, and only one of the children was now living. These results were such as to determine him absolutely never to operate by this method again. This determination was strengthened by the fact that both of his Porro cases recovered. Mr. Tait draws a distinction between the cases where the pregnant uterus was removed before the

completion of gestation for some reason other than that of pregnancy, and those cases where the uterus was removed at or very near the time of labor, on account of difficulty in accomplishing delivery by the natural method. One of the cases reported by Mr. Tait belonged to the former category, the second was a "true Porro." In his first case a cystic sarcoma of the uterus was the cause of trouble; the patient was between four and five months pregnant. The entire uterus was removed. The clamp came off on the ninth day. This operation was performed in August, 1884, and at the date of writing (March 10th, 1886) there was no return of the disease. In commenting on this case Mr. Tait expresses the regret that Dr. James Blundell had not lived a half of a century later than he did, or that he had not possessed the courage of his opinions. "There was hardly one of the recent advances in gynecology that was not to be found in anticipations of his writings." Blundell was the first to suggest the total removal of the uterus. Mr. Tait condemns the Cæsarian section in the following language: "The mortality of the Cæsarian section is a long way over 99 per cent., and in itself it is essentially an immoral proceeding. It is primarily and chiefly based on the medical belief, that any risk to the mother ought to be encountered in order to save the child, even if that child live only long enough to be baptised. This is an immoral principle upon which to decide a surgical question, and it is economically wrong. But the chief immorality of the ordinary Cæsarian section is, that all of the .029 cases of recovery are left to tumble into exactly the same awful trouble immediately after they have recovered from their first ordeal; and, as a matter of fact, many such cases are known where the Cæsarian section has been repeated on the same patient a second and even a third time. I think the time has come to protest against such practice."

Impressed with these convictions Mr. Tait removed the ovaries in his last case of Cæsarian section which was performed in 1880. Mr. Tait takes very strong

ground in favor of the Porro operation. "He was convinced that if he had a hundred cases of Porro's operation, such as that about to be described, before the obstetric art had been exhausted on them, there would not be more than five deaths in the series. He believed that in any case where the impediment to delivery was such as to require the destruction of the child, and to require this inevitably in a subsequent labor, the performance of Porro's operation as a first step would be by far the best decision in the interests of all concerned."

The following report of Mr. Tait's second case will be read with interest: "E. D., aged 33, who had been married five years, was taken in labor with her first child at 2 P. M. on January 8th. A leg presented. On examination, it was found that, whilst there was plenty of room on each side of the pelvis, the inlet was absolutely blocked by a prominence of the sacrum closely approximating the symphysis, and that the limb had passed on one side of this projection. It was determined to perform Porro's operation. This was done in the following way. An incision was made in the middle line, a little short of four inches; and as soon as the peritoneum was fully laid open, a loop of India-rubber tubing was passed over the fundus. It was then passed down as far as possible into the pelvis, and tied tight. A small incision was made into the uterus, and, as recommended by Dr. Godson, enlarged sufficiently by tear to enable the child to be grasped. The child, a fine boy, was easily delivered, and as he emerged, hardly a drop of blood was lost. The uterus was then pulled outside, Kœberlé's wire clamp applied, the elastic ligature removed, and the wound stitched up. The whole operation did not take more than ten minutes, and nothing could be easier than its steps. The stump was dressed with perchloride of iron and iodoform. The only trouble was with the clamp. The tendency of an uterine pedicle was always to shrink; and, although it was tightened in this case at the time of the operation as much as was safe, the shrinkage caused bleeding in a few hours, and this occurred several times,

so that the screw had to be tightened up. He believed the pedicle would be best treated by means of the cautery. The cautery failed in hysterectomy, because there was nearly always some enucleation in the removal of uterine tumours, and, therefore, when the stump was relieved from the cautery clamp, the inside bled. In a pregnant uterus this would not be the case. No kind of treatment by the ligature would be safe, owing to the shrinkage. If the pedicle could be treated by the intraperitoneal method, the mortality might be reduced to something approaching that of ovariectomy. If, however, experience should determine that the extraperitoneal method was necessary, the mortality would probably never fall below 15 or 20 per cent."

### Miscellany.

INTUBATION OF THE LARYNX IN DIPHTHERITIC CROUP.—In a paper on this subject (*Med. Record*, April 10 1886) Dr. Dillon Brown sums up the following points:

1. All the cases were among children called foundlings.
2. The tube was inserted in *every* case of severe laryngeal obstruction that occurred in the asylum without regard to its hopeless character.
3. One-third of the cases were babies aged sixteen, twenty-three, eleven, twelve, and five months respectively, an age at which recovery after tracheotomy is extremely rare.
4. Two (Cases V. and VII.) had tuberculosis, a disease which is in itself absolutely fatal.
5. One (Case III.) a rickety child, died of uræmic convulsions three days after the disappearance of all laryngeal obstruction.
6. The tube requires no attention after its insertion to keep it clean, and if a piece of pseudo-membrane should close it (which is not likely to happen), the tube is held in place so loosely that it would be immediately expelled.
7. The inspired air is warm and moist. This prevents the drying of the secretion in the tube.



8. The head or shoulder of the tube does not rest upon the vocal chords, but just above them on the ventricular bands. There is never any ulceration of the chords, but slight ulceration may be produced by the head and lower end of the tube when retained for a long time. This can do no harm.

9. There is not the slightest danger of the tube slipping through into the trachea.

10. In most cases semi-solid food is taken well from the beginning; but it usually takes twenty-four hours for the child to learn to swallow liquids. Occasionally, in very young children, it is necessary to feed them through a tube.

11. The mouth-gag is intended only for children who have back teeth. In babies there is no difficulty in keeping the mouth open with the finger.

**THE BRAIN SURGERY OF THE STONE AGE.**—Mr. Victor Horsley gave an interesting lecture on Wednesday last in the Botanical Theatre of University College, at a meeting of the Medical Society of that institution. After showing how the earliest implements used for cutting purposes were made either of shell or stone, and having briefly described the mode in which the Bronze age succeeded the Stone age through the utilization of copper alloyed with tin and was followed by the iron and steel periods, Mr. Horsley discussed the evidence that existed as to the extent in which brain surgery existed amongst the inhabitants of the caves and villages of the Stone epoch. By means of the lime-light he showed photographs of skulls which had various kinds of holes. Some of these perforations had admittedly been produced by the pick-axe of the finder. The skulls were from "finds" chiefly in the lower and middle thirds of France, and being found buried beneath the floor of caves side by side with stone implements, the inference was drawn that they belonged to the Stone epoch. Other holes in the skulls were either made soon after death for the purpose of embalming, or were else the witness of an unsuccessful surgical operation. There was again a third class of holes

which were clearly the result of primitive kinds of trephining; for there was evidence in the smooth and rounded character of the edge, the presence of hard osteophytes and even of prolonged suppuration in the form of osteoporotic material, that some of the perforations had been made during life, and the patient had lived long after their production. Most of these specimens belonged to individuals who had been young at the time of operation. The majority of the holes were situated in the parietal region, and, as Mr. Horsley showed, over Ferrir's "motor area." The author also believed that such trephinings had been done for cases of some kind of epilepsy. Altogether the lecture was very interesting, and afforded scope for much ingenious hypothesis, of which Mr. Horsley freely availed himself.—*Lancet*, March 6, 1886.

**RECENT PROGRESS IN HOSPITAL PLANNING AND ARRANGEMENTS.**—It has been well remarked by Dr. Mouat that hospitals have not, as regards their construction and management in relation to the treatment of disease, kept pace with the advance of civilization in other branches of social economy. While, on the one hand, medical and surgical science are constantly and steadily advancing in the path of progress, it must be admitted that, with one or two exceptions, the science which concerns itself with the construction and arrangements of the buildings in which the treatment of the sick has to be done, is very much in the state in which it was twenty years ago. We hear of the same hospital diseases which were supposed to be inherent in the older forms of construction, taking root and flourishing in the newest and most costly buildings; and we look in vain amongst the larger hospitals for any indication of that careful thought for structural improvements, both in general plan and in administrative details, which characterizes in so marked a fashion many of the newer hospitals in France, Germany, and Belgium.

Mr. Keith Downes Young points out in a brief summary of the progress

of hospital building in recent years, which appears in the April issue of *The American Journal of the Medical Sciences*, that exceptions must be made in favor of three classes of buildings: (a) Infirmaries attached to workhouses; (b) hospitals for infectious diseases; and (c) cottage hospitals. Mr. Young dwells on the special features of some of the best examples of these three classes, and concludes by pointing out that in planning a new hospital, or in improving an old one, an essential element of success is a cordial coöperation between committee, medical staff, and architect; and unless these three authorities work together, and not, as is too often the case, the committee scheme, and their architect plans, without reference to the medical staff, failure is inevitable.

**A CASE OF EXTRAORDINARY SEXUAL PRECOCITY.**—The Paris correspondent of the *British Medical Journal* (February 13) gives an account of a case published in the *Semaine Médicale*, and observed by Dr. Mengus, of a little girl of twenty-three months, who menstruated regularly. The child was well formed and fully developed for her age. The menstrual flux proceeded from the genital organs; there was neither lesion, neoplasm, nor a foreign body to explain this. The hymeneal membrane was absent; examination could extend to the cervix uteri, which was excessively developed for a child of that age. After three days, the catamenial flow stopped, and reappeared six weeks later on. The child presented signs of puberty, which increased after the second menstruation; the breasts were as developed as in the mobile period; the pelvis presented the signs of commencing puberty, and the skin lost the satin-like surface peculiar to children, and presented the rougher one characteristic of puberty in young girls; loss of blood weakened the child at first, but a few tonics restored her normal condition; she continued to menstruate regularly and have perfect health; she is now three and a half years old, precocious and intelligent, and measures 1.15 mètres in height, the stature of a child of seven. Her brother presents all the symptoms of cretinism.

## Medical Items.

The fourth annual Commencement of the Woman's Medical College of Baltimore was held on May 1st. The degree of M.D. was conferred upon the following graduates, Mrs. Margaret Bacon, of Baltimore, Miss Julia Hill, of Missouri, and Miss Maria White, of Pennsylvania.

The Sultan of Turkey has decided to send a commission to M. Pasteur's laboratory to study his method of inoculation for hydrophobia. The members of the commission are Zocros Pasha, and Hussein Bey, medical men, and Husni Pasha, veterinary surgeon. Zocros Pasha will present M. Pasteur with the Order of Medjidie and \$2,000, a subscription from the Sultan for the Pasteur Institute.—*Med. Record*.

M. J. Besnier, in a recent work, states that children vaccinated at birth, and subsequently revaccinated, exhibit an increasing vaccinal receptivity from 7 to 20 years of age. After 20 years of age, this receptivity is diminished. Children vaccinated at birth, and subsequently contracting small-pox, exhibit an increasing variolic receptivity from 7 to 20 years of age, when it diminishes.—*British Medical Journal*.

The Illinois State Board of Health at its regular quarterly meeting in Chicago, held April 15, 1886, passed a resolution to the effect that the continuous graduation of 45 per cent. of the total number of matriculates of a medical college—due allowance being made for the average annual loss—must be accepted as *prima facie* evidence that practically every candidate is graduated without regard to competency or qualification; that it be resolved that no medical college be recognized as in good standing within the meaning and intent of the act to regulate the practice of medicine in the State of Illinois, the aggregate graduates of which amount to 45 per cent. of its aggregate matriculates during a period of five years ending with any session subsequent to the session of 1885-86.

The Virginia State Board of Medical Examiners held their first semi-annual session for the current year in Richmond, on April 7th. Two days were spent in examining candidates. Twenty-five candidates for license to practice in the State were examined by the Board and were passed. Eight applicants were rejected, representing four prominent colleges of this country, the names of which are not given. The *Virginia Medical Monthly* in this connection says: "It is not right that the high degree of eminence which their colleges enjoy because of the renown of their professors and the opportunities they have from of proper instruction, should suffer by reason of setting sail upon the professional sea waifs that are unfit to leave the shore. We appeal to them in the spirit of common justice to the profession, from which they derive their support, to be more careful in the future as to the merits and ability of their candidates."



Original Articles.

ALBUMINURIA.\*

BY JOSEPH T. SMITH, M.D.,

Visiting Physician to Bay-View Asylum.

Few words in our medical vocabulary are in such constant every day use as albuminuria; at the same time there are possibly none which, from a clinical point of view, give us such a vague idea of the real condition of things; it is a hybrid term signifying "a condition of the urine in which it contains albumen \* \* \*." It is a word used to express the fact that the urine contains albumen and that of peculiar kinds, but it gives us no idea of the source from which the material comes, nor of the diseased condition or conditions which produce it, if indeed it may not exist in the urine from a perfectly healthy body; still more, we cannot say from the presence of albumen alone whether the kidneys are at fault, or disease is lurking in remote organs, as the liver or lungs. Failing thus to give us any positive information upon points so vital, the presence of albumen in the urine can be of value only as a symptom, oftentimes only one of many, to help us map out the path to a correct diagnosis; just as we find fever a symptom of inestimable value in pointing out the course and gravity of certain diseases, so we find in others that albuminuria is an important guide-post to indicate the road, but neither is of much value in and by itself.

Possibly upon no one symptom, unless it be that of fever, has more time and thought been expended than upon albuminuria; it would no doubt be a surprise to all of us could we know how many gallons of alcohol and nitric acid, to say nothing of other chemicals, have been poured forth in the search for this otherwise invisible substance in the urine. The journals, in almost every issue, contain one or more articles upon the subject; in the last issue of one the best, is published an article on Ferro-

cyanic pellets as a means of detecting albumen; indeed if one looks at the literature upon this one subject to-day, he would think it a something new, so full and voluminous is it, instead of dating back to 1827 or earlier, at which time Dr. Bright thought that in dropsy with albuminous urine he had discovered the golden key which would unlock the secret of disease of the kidney, instead of opening up the path to the diagnosis of very many distinct diseased conditions, and these not of the kidneys only, which were but faintly outlined in his mind at the time. From 1827 then until the present day, a period of nearly 60 years, this subject has claimed the attention of the medical world and still many points call for discussion. How shall we find this invisible substance? The journal mentioned above contains four articles relating to the tests to be employed, showing that not yet have we reached a satisfactory agent or agents; what does its presence indicate, some fatal form of kidney disease in the pregnant woman or a simple condition which shall disappear with the birth of the child; does its presence always point to a morbid condition somewhere or can it be found in the urine from a perfectly healthy body; whence comes it, from the blood primarily or from that fluid altered by the cells of the tubuli? These and many more are questions still unanswered and until they are, each and all of us may be pardoned for discussing a subject sixty years old at the least.

The first question which presses for an answer is how shall we discover the existence of albumen in a given specimen of urine? The agent or agents used must show the presence of albumen with absolute certainty, the reaction must take place quickly, the application must be easy and free from danger and the materials must be in a such a form as to be conveniently carried. The search for such a chemical or other agent which shall combine in itself all these conditions has occupied the thought of our best men, but thus far without effect; we know of nothing which will fulfil our desires in this matter. The

\*Read before the Clinical Society of Maryland, April 2, 1886.

most important element is that of certainty and any agent or set of agents, no matter how they may fail in all other respects, if we can always depend upon them to point out the presence of albumen, are the ones to which we must resort, and such we find in heat and nitric acid; they possess this quality of certainty in a preëminent degree. The objections to them are, however, obvious, the acid being so unpleasant to handle and its powerful destructive properties making it necessary to employ care in its use; the heat is not always available. I mean clean heat like that from an alcohol lamp. In spite of these objections these agents up to the present hour are the final resort in all cases of doubt, if aught else is used. Roberts says the best tests for albumen "are coagulation by boiling and nitric acid," and again "the clear superiority of nitric acid in regard to the precision of its indications is an inducement to seek for some means whereby its objectionable qualities may be mitigated." Da Costa remarks, "there are several other methods enabling us to ascertain the occurrence of albumen. Of these the chief are: heat, which coagulates the albumen; nitric acid, which causes a white precipitate. Of all the proposed substitutes for heat and nitric acid probably none has come so near our ideal as picric acid, an agent comparatively clean, easily carried and readily applied, but experience with it shows it to lack certainty. As Dr. Harris well observes, "in the majority of cases its results are perfectly satisfactory and it detects a very minute quantity of albumen; but I feel sure that, occasionally, it gives no indication of the presence of albumen when a small amount is undoubtedly present, as shown by other tests and still more frequently does it give a reaction which is indistinguishable from that which a trace of albumen produces, but which is not due to albumen. \* \* \* Specimens of urine containing mucin and no albumen, give a reaction with picric acid which cannot be distinguished from that produced when albumen is present." It will throw down mucin and peptones, leaving us in doubt which must be cleared up by other agents.

Metaphosphoric acid is an extremely delicate test for albumen, but we find its solution very unstable; as a solid it deliquesces, dissolves but slowly and any undissolved portions in the test tube are removed with difficulty.

Yellow prussiate of potash with acetic (citric acid) offers attractions from the fact that it can be put into pellets and so be convenient for use and easily carried, but its deep staining qualities and difficulty of manipulation render it objectionable and more than all it will throw down mucin. Albumen tests of a valuable and attractive form are slips of paper, like slips of litmus for acid testing, and as such have been prepared with potassio-mercuric oxide, they were tried but it was found that all urines are affected by the test more or less, so this has been abandoned. A most convenient test suggested by Dr. Roberts, because it can be made at any time and readily, is that of acidulated brines, but this will throw down the peptones, and the doctor gives it but slight mention in his last work. An approach to the abolition of the very objectionable features of nitric acid is the addition of five volumes of a solution of sulph. of magnesia to one volume of the strong acid. Dr. Roberts claims first that the mixture is colorless, will not fume nor burn, of such sp. gr. (1.240) that it will readily sink to the bottom of the test tube, is more prompt and sensitive than the pure acid and acts less strongly than the pure acid upon the coloring matter of the urine. Dr. Harris, in the *Medical Chronicle*, amply confirms these statements. It is to be used in all respects as the pure acid.

In view of all these facts, and we have only noted a few of the best agents suggested, we must still assign to heat and nitric acid the first place.

Having determined the presence of albumen, what does it signify? Does it mean that we have a something abnormal or can it be present and the individual be in a thoroughly healthy condition? Observation and experiment seem to point to the fact that urine containing any considerable quantity of albumen is from an unhealthy body;



the disorder may be slight, but good health is not compatible with well-marked albuminous urine.

If, however, the amount is small, but a trace indeed, there may be a condition such as Robert's terms physiological albuminuria; this is a condition of things difficult to recognize; we must find the amount of albumen small; it must not be constantly present, that is it must be intermittent, absent, for instance, in the urine passed in the morning but showing itself during the day after food and exercise, as Brown-Sequard has shown its presence after a full meal of eggs; finally the albumen must be long continued. Supposing it to be a normal product we know, as yet, no way of determining the fact from the discovery of albumen alone, how much shall be looked upon as normal, and when the normal becomes abnormal we can only determine by a careful inspection of the whole body, and if we find no diseased condition we say the albumen is a normal product; the simple presence of albumen tells us nothing, it awakens suspicion only. Again there seems to be no doubt that many cases looked upon as physiological, if carefully looked into, will be found to depend upon some systemic fault, not it may be in the kidneys, but elsewhere, as in those broken in health or who suffer from dyspepsia. Dr. Mahomed states that "he found albumen in the urine in 9 out of 58 persons (namely 15.5 per cent.) thought to be healthy, whom he examined for life insurances. It was shown that 7 out of the 9 cases were not in perfect health. At best then physiological albuminuria is exceedingly rare and a case should not be pronounced such until the fullest examination of the whole body is made. So far as we know now even a trace of albumen should cause apprehension and we should not rest until we have exhausted all sources of information as to cause. Dr. Greenfield remarks in this connection, and we heartily agree with him: "There are cases—I have had such under my care—in which there was no evidence of disease beyond the presence of albumen in the urine, and in

these cases not merely intermittently but in one or two cases continuously, during a period of some months though in variable quantity. In the cases to which I refer there was neither dropsy nor cardiovascular changes, and none of the serious disturbances which we find in Bright's disease; these subjects were especially anæmic young women.

The urine was usually pale, clear, of low sp. gr., often phosphatic, and contained neither casts nor blood. But are we on this account to say there is no disease, that it is a physiological albuminuria? I believe that as pathologists we are bound to allow of no such conclusion without the most exhaustive analysis and conclusive evidence."

If we look at the list of diseased conditions in which albumen may be found in the urine, we will find them almost legion; so many and so diverse are they indeed that one learns but little as to their nature from the fact that albuminuria is present. This is a symptom of so little moment in many conditions that we do not even look for it. Such is true of rheumatism, ague, measles, etc.; in others, on the contrary, it is eagerly sought for that we may know the tendency of the diseased conditions present, as after scarlet fever and certain forms of Bright's disease, still even here it has but a secondary place, for without the microscope and a thorough examination of the patient, we can learn but little of the actual conditions present. Still further, even in some forms of fatal disease, as after scarlet fever, no albumen may be found, showing that thus even when you would look most for it, it may disappoint you by its absence. Upon this point Dr. Greenfield well remarks: "It is a well-known fact that extensive diseases may exist in the kidneys, remaining for a long time entirely latent, and reveal itself by some terminal fatal phenomena, or be discovered after death. I have for some years made it a special object to examine all kidneys whether obviously diseased or not, whenever opportunity permitted, more especially in cases of men dying over the age of 30, or dying from acute diseases of all kinds, and have

been struck with the frequency with which changes of an extensive character have been found where none were suspected during life."

One need but glance at the various bodily disorders, in which albuminuria exists, to see with what comparative ease the urine can be made albuminous; not even a diseased condition need be present, simply throw too much albumen into the blood and in an altered form you will find it in the urine. The pathology of albuminuria is still a somewhat vexed question, the old idea that albumen is thrown out from the blood to be reabsorbed by the cells of the tubuli and so kept from showing itself in the urine having been disproved, has been replaced by that of Heidenhain, who taught that the albumen is kept back by the cells covering the outside of the glomerular tuft; so long as these are in good condition, the arterial tension not too great, and the blood not surcharged with albumens, these tests will fail to show an albuminous urine. Any condition of the cells of the glomerular tuft that will interfere with their function then may cause albuminuria, and as these may be true secreting cells, like those of the salivary and sweat glands, it is not difficult to explain how it is that so many diverse conditions have this one symptom in common.

As with all secreting cells, those of the glomerular tuft are very sensitive to any change in the blood supply to the tuft, thus heart troubles, fevers, inflammation, and that large class of diseases which cause increased arterial tension will cause these cells to allow the passage of albuminuria; in the latter case it may be as some one has suggested by a partial tearing of the cement substances that binds these cells together, that thus the albumen escapes.

The cells of the glomerular tuft, if their function is now correctly known, are influenced by the slightest changes, oftentimes, in their blood supply, and the slightest disturbances of the normal circulation will cause albuminuria.

Dr. Mahomed indeed looks upon the increase or diminution of the circulation of the blood in the tufts as the two condi-

tions most likely to produce albuminuria; indeed they are the chief causes.

Thus the kidneys, like other organs, become congested, this may go no further or may end in inflammation, and the cells covering the glomerular tuft show circulatory interference by allowing the albumen to pass out; in the one case it soon disappears, in the other it is increased in amount, and frequently the cells become more and more unfit to perform their function, and the first stage of Bright's disease, according to Frerich's is fairly established.

We had intended to note other points in this interesting part of the subject, the difference in function of the cells of the glomerular tuft, and those lining the tubuli, the mode in which the blood-currents influence the presence of albumen in the urine, how it is that the first signs of destructive disease commence in the glomeruli and tubuli, and thus cause albumen to be one of the first symptoms; but our time is already we fear more than exhausted.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING, HELD APRIL 2ND, 1886.

*Dr. O. J. Coskery* read some notes from

#### A CASE OF ARTIFICIAL ANUS.

*Dr. S. T. Earle* called attention to a case similar to that of *Dr. Coskery*, reported in the *London Lancet* for May, 1885. The operation terminated fatally because of the puncture of the peritoneum. He asked if the plan advised of dissecting out the coccyx and turning back the rectum was not the preferable way of relieving these cases.

*Dr. Randolph Winslow* said it seemed to him, that a cutting operation, the splitting of the anus to the coccyx and if necessary the removal of the coccyx, and the bringing down of the rectum and uniting it with the anus,



would have been much more satisfactory in its results and much less severe on the child, than the method pursued in this case. Even if the bowel was fortunately entered by the trocar, without injuring some of the neighboring viscera or the peritoneum, the difficulty of keeping a hole, tunnelled through the tissues, patent, was a very great objection to the method. As was well known the parents of a child would be likely to neglect systematic dilatation and the channel would close, as it had done in the case reported three times already. When the mucous membrane of the rectum can be attached to the anus this tendency to contraction is nearly overcome. If it is impossible to attach the rectal mucous membrane to the skin, a colotomy would probably be the preferable operation.

*Dr. Coskery* thanked *Dr. Earle* for calling his attention to the article in the *Lancet*.

The course pursued by him in his operation was the one desired by the parents of the child. He gave them their choice of the operations and they united upon the least bloody one being done.

Were he called upon to do the operation again, he would adopt the plan of drawing down the rectum and uniting it to the external surface. He did not understand how *Dr. Winslow* could prefer a colotomy, when often by an incision two inches deep one could easily enter the rectum.

*Dr. Earle*, in speaking of the adhesions so often met as an obstacle to drawing down the rectum, gave as his opinion that they are not congenital, but are rather the result of manipulation with trocar and canula.

*Dr. John Morris* while in the Dublin Rotunda saw two cases of congenital imperforate anus. In one, there was a *cul-de-sac* leading a short distance into the soft tissues, and in the other there was but a depression at the point where the anus should have been. Both cases terminated fatally. The latter one was operated upon after the trocar and canula method and at the autopsy the bladder was found to have been punctured.

*Dr. Joseph T. Smith* then read a paper on

#### ALBUMINURIA.\*

*Dr. J. H. Branham* said that *Dr. Smith's* statement, that the cells covering the glomeruli had a secretory function, was contrary to what he had been taught. He took them to be only a flat epithelial covering, purely mechanical in their function. They acted, according to his ideas, as a filter, through which the watery and saline elements of the urine exuded. The cuboidal cells lining the tubes, he thought the true secretory elements.

*Dr. I. E. Atkinson* considered the comparative anatomy and physiology of the kidneys in different animals a very interesting study. For example, in birds, where there is no passage of true watery urine, the tubes are very long and convoluted, thus admitting of the reabsorption of the watery elements, and the passage of the solid constituents as solids; in fishes we see just the reverse, here there is no retention of the watery portion and we find the tubes straight and simple, admitting of the passage of the urine just as secreted.

He believes the epithelium covering the tufts different from that lining the tubes; he doesn't consider it a true secretory structure and does think that the cuboidal cells of the tubes are the secretory elements of the kidneys.

Nitric acid and heat, or *Heller's* test of nitric acid alone, he thinks; sufficiently accurate for all practical purposes, in detecting the presence of albumen in the urine. Uric acid is sometimes thrown down, but this is easily recognized. A rather more convenient form in which reagents may be carried about, he finds in the test papers prepared by *Park, Davis & Co.* They are handy and he has found them tolerably accurate.

*Dr. C. O. Miller* referred to the experiments done upon the frog in *Heidenhein's Laboratory*, in which it is shown that the epithelium covering the glomeruli have a true selective action. He thinks, however, that an objection of some

\*See page 41.

weight may be made by the possible degeneration of the cells caused by the injection mass employed, and thus their true function altered.

*Dr. Joseph Blum* has employed the test papers referred to by *Dr. Atkinson*, and finds, that excepting the picric acid ones, they all deteriorate after a time.

*Dr. J. H. Branham* read a paper on

#### PERINEORRHAPHY.

Mary Johnson, col., age about 20 years, was confined on December 1st, 1886. The position was right occipito-posterior and the child was large.

The second stage of labor lasted for nine hours and was finally terminated after great difficulty by the use of forceps. Notwithstanding great care exercised by a skillful operator, an extensive rupture of the parts occurred.

I first saw the patient about two hours after the labor was completed. The rupture included the perineum, the posterior wall of the vagina to the extent of two and a half or three inches, and an inch and a half of the rectum. It began in the middle below and extended upward and to the right.

The tear through the perineum was ragged, and the sides were trimmed before bringing them together.

Three rows of sutures were used one in vagina, one in the rectum and the other in the perineum. Some difficulty was experienced in introducing the high vaginal sutures, otherwise the operation was easy.

Before introducing the sutures the parts were thoroughly cleansed by bichloride solution, strength one in two thousand parts of water. Small iron wire was used for sutures.

After the operation a rubber tube with a number of openings in it was introduced into the vagina, the distal end being in a bottle of bichloride solution. This acting as a syphon carried off the lochia almost entirely. Parts were disinfected twice daily by fluid passed through this tube, bichloride being used part of the time and carbolic acid part of the time. Bowels were closed by opium during

first six days, liquid food being given. Patient did well, highest temperature being 102° on fifth day.

Sutures were removed on twelfth day, when good union was found, all the tear being healed except at the back part of ostium vagina and fourchette. The union was partly by first intention and partly by granulation.

What is the prognosis of primary operation in complete rupture?

Tait (page 34) says: "If the case be seen immediately after the rent has been made, stitches may be applied without any preliminary paring; but this practice has never had a satisfactory result in my hands; for in all the cases where I have been called in to perform it, the tissues have been so bruised and the edges have been so ragged that a satisfactory union has never been effected save by a subsequent operation. It is, however, worth trying?"

Others have met with little better results. I attribute the success in this case to drainage and antiseptis, and think that unless such measures are carried out there is little chance of a good result. The vagina tends to dilate and the lochia to collect in it, when unless some means are employed to prevent, it undergoes decomposition and prevents union.

*Dr. W. Pawson Chunn.*—Was there any recto-vaginal fistula?

*Dr. Branham.*—None whatever.

*Dr. Chunn.*—What was the object of stitches in the rectum?

*Dr. Branham.*—The rectum was lacerated for and one one-half inches, and the stitches were put there to restore this laceration. Their twisted ends were on the mucous surface of the rectum, and they remained in position for twelve days.

*Dr. Chunn* said his reason for asking so particularly about the stitches in the rectum, and the position of their twisted ends was that such efforts were usually not so successful as *Dr. Branham's* had been. The plan usually adopted with success was to twist the wires on the mucous surface of the vagina.

*Dr. Randolph Winslow* thought *Dr. Branham* could scarcely claim much of the good result attained in his case, as



due to the antiseptis, which seemed to him to be very defective, being antiseptic only when the irrigations were being practised, with an abundant opportunity for the entrance of germs in the intervals. After considerable experience in perineorrhaphy, Dr. Winslow had discarded wire sutures entirely, and now used antiseptic silk. The results were equally as good, the difficulty of introduction and removal of stitches very much less, and the comfort of the patient much greater. In cases in which women have been operated on twice, once with wire, the second time with silk, they express themselves strongly in favor of the latter. The continuous catgut suture is probably better than either, as the necessity of removing the stitches is thereby avoided.

#### FOREIGN BODY IN THE NOSE.

*Dr. John N. Mackenzie* related a case of foreign body in the nasal cavity of a child, the removal of which was facilitated by the use of cocaine. Dr. Mackenzie regretted to be obliged to intrude upon the Society's time by bringing before them the much-talked-over cocaine, but in this case it proved itself of so much service that he considered himself justified in calling attention to its value in such cases. When he saw the child there was a bit of bone very tightly wedged between the corrugated mucous membrane. An attempt to remove it with forceps failed. He applied cocaine to the tissues in order that its power of causing contraction might lessen the pressure and enable him thus to remove the foreign particle. This effect was produced in a few minutes, and the bit of bone was easily removed.

*Dr. H. Clinton McSherry* had been in the habit of using cocaine with most happy results in obstinate cases of epistaxis.

#### GONORRHOEAL OPHTHALMIA.

*Dr. Samuel Theobald* referred to a case of gonorrhoeal ophthalmia that he had recently seen. When the patient presented himself the left eye only was

affected, and had been so for three days. The lids were swollen, ecchymosis was present, and the cornea was sloughing at its upper margin. Right eye was at this time entirely free from the trouble. In spite, however, of every precaution the right eye took on a similar condition. Treatment was at once instituted. The eye was painted over once daily with a 15 grains to 5 of nitrate of silver solution, three times daily, with a 2 grains to 5 of same drug. After each application the silver was washed away with sodium chloride solution.

Beside this, boracic acid solution was instilled every four hours, and atropia employed daily. The left eye is lost. The right eye is entirely under control. This the doctor attributes to prompt treatment; he thinks had the right eye gotten fairly under way that it would have been destroyed.

#### HEMICHOREA AND HEMIPLEGIA.

*Dr. Preston* related a case of a girl whom he had recently seen. She had hemiplegia on one side, and hemichorea on the other. The chorea came first and was followed by the hemiplegia. He thinks the chorea was caused by a minute embolus, and the hemiplegia was the result of the consequent softening or by a second larger clot. He considered the case interesting, as probably shedding some light on the pathology of chorea.

#### OBSTETRICAL SOCIETY OF PHILADELPHIA.

SPECIAL MEETING, HELD APRIL 15TH, 1886.

(Continued from last issue.)

The President, B. F. BAER in the chair.

#### VAGINAL HYSTERECTOMY.

*Dr. Wm. Goodell* exhibited a womb which he had removed per vaginam. The woman had been brought to him by Dr. F. R. Gerhard, of Douglassville, Pa. She was 65 years old and had given birth to twelve children. She

had a hypertropic elongation of the of the womb, the sound giving a measurement of minus five inches. Her cervix was outside of her body, and it was very greatly enlarged in every direction by a carcinoma. On March 10th, before the students of the University of Pennsylvania, he amputated the cervix after applying an elastic ligature; but finding that Douglass's pouch had been opened, he concluded to perform the radical operation. The womb was accordingly retroverted, its attachments to the bladder severed, the broad ligaments tied *en masse*, each with two strong ligatures, and the womb removed. The large gaping wound was closed by seven wire sutures, leaving only a small opening through which the ligatures passed and acted as drainage tubes. Sublimated cotton was lightly packed into the vagina. This was removed twice a day and the wound syringed out with a one-to-two-thousand solution of mercuric chloride. On the next day the temperature rose to 100.2°, but it never after that day reached 100°. The sutures were removed on the fourteenth day and with some difficulty, as they were now high up in the apex of a cone-shaped vagina. She was able to go home on the twenty-third day after the operation.

*Dr. H. A. Kelly* remarked that he wished in this connection to emphasize a point of vital importance in every operation where there is either artificial or pathological descent of the cervix proper. The slightest traction, elongating the cervix, draws the vaginal vault down over the displaced supra-vaginal portion, like the finger of a glove and unless especial care is directed to this point, there is imminent danger of scalping the vagina in any operation then performed on the cervix. In lacerated cervix, particularly where Dawson's scissors are used, (and great downward traction is fashionable) the bases of the broad ligaments are opened in this way; and in amputation intended to be limited to the infra-vaginal cervix as in this case of *Dr. Goodell's*, either the scalping process lays bare a broad tract of areolar tissue in the vault around the cervix, or worst of all, Douglass's pouch

is laid open. It is unnecessary to enlarge upon the greatly increased dangers of septic infection. He would ask *Dr. Goodell* in regard to the after-treatment of this case. In the latest contribution to this subject by *Dr. Brennecke*, of Madgeburge, in the *Zeitschrift für Geburtshulfrund Gynecologie*, he clearly shows that those cases ran a most favorable course in which the iodoform tampon was not removed for six or seven days, and that syringing after operation with a view of carrying off foul discharge is a pernicious practice as it separates the peritoneal surfaces which have just formed delicate adhesions and breaks up the early steps of repair without the possibility of accomplishing its purpose. A point well worth attention is Brennecke's method of dealing with the upper part of the stump of the broad ligaments which are caught in stout ligatures. Experience has shown that the distal end is very apt to slough, and to secure an immunity from the dangers of sloughing, Brennecke ties the ligatures of opposite sides across and everts the two stumps, thus fastened together, into the vagina where they cannot do harm, and help form a plug for the wound.

*Dr. Montgomery* questions the propriety of total extirpation of the uterus. How long is the patient likely to live after this operation? If partial removal gives equal relief from the disease for which the operation is performed, and an equal or greater chance for a prolongation of life, it is to be preferred as the least dangerous. Hoffmiller, in a summary of German gynecological work, opposes total extirpation if it can be avoided. He reports 145 cases of partial and 39 of total removal of the uterus. Ten of each series were fatal. In six of the partial cases the result was unknown. Of the total removals six only were living at the end of two years and none at the end of three years; while of the partial six still lived at the end of the fifth year. Following the plan suggested by Sims and Van de Warker in cases of malignant disease of the cervix, *Dr. Montgomery* makes an incision into the uterus at the vaginal junction and



dissects upward as closely as possible to the peritoneal surface, while making traction on the cervix; thus, as it were, enucleates the uterus, leaving a very thin wall; he then stuffs this cavity with a mixture of equal quantities of zinc chloride and water on cotton tampons to cause a slough of any diseased tissue that may have been left behind. If by chance the sloughing should perforate the peritoneum, the previous inflammatory exudation would save the peritoneal cavity from invasion.

*Dr. H. A. Kelly* does not wish the claim of an eminent American surgeon to priority in this matter to be forgotten. The credit of originating the highest practicable cone-shaped amputation of the uterus and establishing its great utility, its safety and relative greater success is due to *Dr. Baker* of Boston. He uses no cautery and controls hæmorrhage perfectly by the effect of strong downward traction upon the vessels.

*Dr. Parish* mentioned an earlier operation by *Hirth*, of San Antonio, Texas, who practiced the method described by *Dr. Montgomery*, of enucleating the uterus from its peritoneal covering. He divided the vaginal mucous membrane and gradually shelled or scooped out the uterine tissue. The operation was accompanied by great hæmorrhage.

*Dr. C. M. Wilson* thought such an operation very dangerous and liable to be followed by secondary hæmorrhage. He has in two cases after *Dr. Baker's* method used a hot tamponade of the uterus and vagina after the operation. *Dr. McCormick*, of London, packed the stump with bandage or gauze filled with iodoform and allowed it to remain undisturbed for nine days. This was perfectly sweet when removed and is a good and safe plan of after treatment.

*Dr. Goodell* said the method of *Brennecke's* of not washing seemed to him to be undoubtedly a good one and he would in future adopt it. He once had an alarming hæmorrhage from the division of a large vessel after a hole had been accidentally made in *Douglass's* cul-de-sac in the high amputation. Consequently he could not pack the vagina for fear of forcing blood etc. into the

peritoneal cavity, and he had to control the bleeding by twisting a wire around it. He generally uses *Paquelin* to control hæmorrhage in these cases, and has operated upon at least 200 with only four deaths. Neither of the fatal cases were high operations. One death was from secondary hemorrhage, one from tetanus, one from a frank peritonitis and one septicemia. He thinks the high operation the most feasible one in the majority of cases in which the womb is movable and he has extirpated the womb but twice for carcinoma.

*Dr. H. A. Kelly* exhibited the sac of an

OVARIAN TUMOR THAT WEIGHED AT NORMAL 100 POUNDS.

*Dr. Goodell* congratulated *Dr. Kelly* upon his success in removing such a large tumor. He, *Dr. Goodell*, had on one occasion removed a tumor weighing 112 lbs. from a woman who after the operation weighed 74 lbs. As in *Dr. Kelly's* patient the tumor reached the patient's knees and she could not lie down. After the operation the large folds of the stretched skin were a great annoyance, but after some months it had entirely contracted. The patient made a complete recovery.

*Dr. M. Price* had been present at *Dr. Kelley's* operation. A large vein was torn and a stream of blood as large as his finger poured out. The patient collapsed instantly, and *Dr. Price* thought her dead, but he was surprised and pleased at a hypodermatic injection of 5i of sulphuric ether which restored the pulsation quickly.

*Dr. H. A. Kelly* exhibited the

OVARIES AND TUBES FROM A CASE OF CHRONIC OVARITIS, SALPINGITIS AND PELVIC PERITONITIS. ALSO THE RIGHT OVARY AND TUBE FROM A CASE OF CELLULITIC CONTRACTION OF RIGHT BROAD LIGAMENT WITH DISAPPEARANCE OF THE MESO-SALPINX AND COHERENCE OF OVARY AND TUBE,

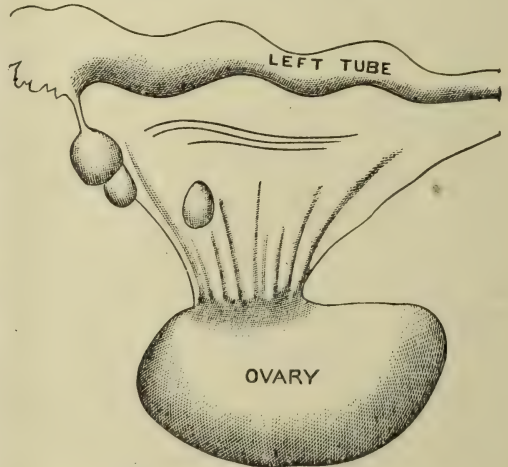
of which the following is the history: *H. P.*, married, age 32, IV parous, has

always been irregular in her menstrual function, the flow generally appearing from ten days to two weeks later than expected and being scant. Her last confinement was eleven months ago. Labor was slow but no instruments were used. The child died in two months. Ten days after delivery she had an attack of typhoid fever (*Sic*) and since then she has never been well. During the fever which lasted many weeks, she had constant severe pain in the right ovarian region, and had repeated chills and flushes of heat. She has at present severe pain in the right ovarian region and constant headache, is unable to work or exert herself in any way. She has not now menstruated for two months although regular before. She has a leucorrhea which is intermittent in character. Bimanual examination reveals an enlargement on the right side extending from the middle of the hypogastrium two and a half inches to the right, downwards to the pubis and upward almost half-way to the umbilicus. It is most prominent above, very tender and semi-fluctuant; every movement of the mass carries the cervix with it. The cervix points to the left, and the right fornix is very shallow. The mass has no firm attachment to the pelvis but is easily movable. It seems to spring from the right cornu-uteri.

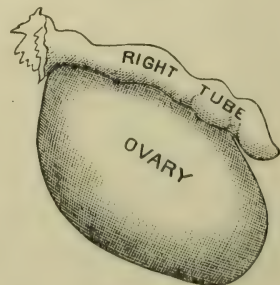
*February:* Pain and sensitiveness great. The right fornix obliterated and the uterus drawn bodily to the right side by a shrinkage in the mass. There is a mass which is as hard as bone on the left side, like a finger, high up behind the vagina, pointing down in its axis.

*March:* After faithful and prolonged treatment, consisting for the most part of rest with counter-irritation in the vagina and on the abdomen, and hot douche and glycerine plug I made an exploratory incision, at my private hospital, on March 27, in the presence of Drs. R. P. Harris, Charles Herman Thomas, P. G. Clark, Marie B. Warner, Boyle, of Kansas, Bull, of Missouri, Baldy and J. W. Mecaskey, to whose courtesy I was indebted for the case, and assisted by Dr. Jas. Hoffman. The right

cornu-uteri was found elevated and matted with a mass of mesentery in which it was completely encapsulated. This was slowly detached layer by layer and the vermiform appendix separated for an extent of two inches. The tip of the appendix gave rise to troublesome bleeding, finally checked by cautery. An enlarged ovary with a withered tube intimately adherent to its periphery was then raised with great difficulty.



A block walled cyst, about one and a half centimeters in diameter, burst and a quantity of grumous matter escaped into the peritoneum. The ovary and tube were removed with great difficulty and a part of the hilum was left in the grasp of the ligature. This was carefully burned.



The illustration gives a correct indication of the structural changes in the right ovary, tube and ligament. The left ovary and tube, which were free and sound, I also removed as I was anxious to stop all determination of blood to the uterus. The figure shows well the contrast between the two. The



operation was protracted, lasting one and three-quarter hours. The patient died on the seventh day of one of those remarkable insidious attacks of peritonitis. She appeared to be doing well until the seventh day when I found her with a wild frightened look and a pulse of 200. She had no pain at all. I broke up the adhesions in the lower part of the wound which looked well, but I could not reach anything within the wound, and she died in two hours. Dr. R. P. Harris was present at the autopsy a few hours later. The recti had a deep red unhealthy appearance, and a few spots of pus lay in the floor of the wound opened down to the peritoneum. The peritoneum was firmly glued together and my effort in the morning had not penetrated it, for as soon as the adhesions loosened a large quantity, at least a pint, of brown pus rushed out and I found the whole posterior part of the pelvis shut off from the general peritoneum by firm agglutination of the viscera above and full of the same material. My chief anxiety was to find the vermiform appendix and see if I could blame it for any share in the result. It was found with difficulty and was covered with a thick finger of lymph. The sepsis came from the matter which escaped from the ovary. I say this for I have never yet seen sepsis in any clean case. Then in looking back for unnoticed symptoms for future guidance in such cases, several points deserved closer attention than they received. 1st She complained more than usual of pain in the first three days. 2d. The pulse remained about 112 instead of dropping below 100 as usual. 3d. She wondered a little occasionally, insisting once that she saw a man in the room. She was more nervous about herself than any of my other cases had ever been, often insisting on sending for me in the night. These signs taken together are certainly significant in the absence of pulse and temperature indications.

Dr. R. P. Harris saw both the patients from whom these specimens were removed. The ovary in the latter case presented a very peculiar appearance; it

was cartilaginous with small cysts. The material escaping from these cysts caused septic peritonitis. The first patient was wonderfully changed by the operation. She was free from pain for the first time in twenty years, and could scarcely be kept quiet so great was her joy at her release.

A UNIQUE CASE OF EXTRA-UTERINE PREGNANCY. COMPLETE REMOVAL OF THE SAC AND CONTENTS.—RECOVERY. BY HOWARD A. KELLY, WITH A CRITICAL EXAMINATION OF THE CASES OF FARRADIC FELICIDE AND REMARKS UPON ITS DANGERS, BY DR. R. P. HARRIS.

Mrs. J. B., 22 years of age, married three years, of medium size, well built, but rather pale and worn looking; has been twice pregnant, the first being a premature still birth, the second a cross birth, necessitating turning by the feet. Since the last pregnancy she menstruated seven times. In July she menstruated for the last time for four months when the flow came on (in November), at which time she passed a piece of flesh called by a doctor a "false conception." Previously to this she had noticed a swelling in the right ovarian region which gave her severe pain. This pain was constant until the flow came on when it was relieved. In December, three weeks after this flow, she thought she felt life and believed she was pregnant. She then had colostrum and a dull pain in the breast, and the nipples were coated with a waxy secretion.

*Examination.*—A tense, smooth elongate, ovoid sac lay in front of the uterus, (which reclined in the hollow of the sacrum) and rising out of the pelvis, reached half way up the umbilicus as she reclined on her back. The tumor was very tender on pressure and presented a remarkable smoothness and uniformity of its surface. It had a tense fluctuant feeling and was distinctly moveable as distinct from but closely connected with the right side of the uterus. She menstruated regularly in January, February, and March, the flow being lighter in color and much more profuse, lasting two or three days longer than her normal menstruation. On

March 13 she was menstruating freely, and the note states "the uterus lies, small in size, in the sacral hollow, and in raising the finger from the cervix to the vaginal wall, an elongate, ovoid, tense cyst is felt on the right side; it is about three and a half inches long by two and a half wide. The cyst lies in the plane of the superior strait. The anterior extremity of the ovoid lies at the pubis and its posterior, attached extremity at the right cornu-uteri. A well-defined sulcus exists between tumor and uterus, and the two are connected by a short but distinct pedicle. The tumor is very smooth and of a remarkable rubber ball elasticity. It is movable over an excursus of one or two inches, but too tender to manipulate further." These notes were made a week before the operation, which was upon March 20. I then wrote to Dr. R. P. Harris that I expected to operate upon an extra-uterine cyst and upon March 20, assisted by Dr. Jos. Hoffman and in the presence of Drs. R. P. Harris, Chas. H. Thomas, Marie Werner, Wm. Stewart, Baldy, Chas. M. Wilson, Jos. Gibbs, R. Keely, Paris G. Clark, McConnell and others, the sac and its contents were removed. The belly walls were fat. The incision was about three and a half inches in length, through the linea alba beginning about one inch above the pubis. The sac wobbled about so in the pelvis that it was hard to bring its globular form up under the line of incision. It felt at first like an enlarged uterus, but the uterus lay retroposed, anteflexed, reclining in the sacral hollow. The tumor was raised and brought out of the pelvis by passing two fingers in front of and under it, hooking it up and revolving it on the axis of its attachment at the broad ligament; it was then delivered through the linear incision by pressing the walls outward and towards the patient's back until it slipped out, it was then transfixed below its base and tied, and with the ovary and whole of the right fallopian tube, was removed intact. The cyst was reddish-blue in color and developed in the free margin of the right fallopian tube, its largest diameter crossing the axis of the tube at right angles. Pure

water was used for the sponges and the instruments were kept in a dry pan. No antiseptic of any sort was employed. Everything was thoroughly cleaned and prepared beforehand and no antiseptic was needed. The whole operation from beginning to complete closure lasted forty minutes. Silk-worm-gut sutures, about four inches, were used to close the wound, and with a little iodoform powder and dry absorbent cotton the dressing was complete. The sac was about three inches long by two and a half wide, smooth and slightly rugose in its long diameter. Dr. Chas. Herman Thomas incised it at its free extremity, cutting through the placenta into the amniotic sac, which did not contain a drop of fluid. The hands and then the head of the brownish, exsanguine foetus protruded, its cranial bone well developed. There was not the slightest fetidity. The whole foetus was well formed and perfectly preserved. It was a male measuring  $5\frac{1}{2}$  inches in length, the cord was five inches long twisted from left to right. The recovery was as rapid and perfect as after any simple abdominal operation. An objection which naturally presents itself and one which has been urged is this. Here was an extra-uterine cyst containing a mummifying foetus in just the condition we tried to obtain by farradic feticide. Why interfere with it all? My reasons were several. 1st. My patient was constantly suffering from a painful tumor. 2d. She had deteriorated greatly in health and in place of her usual fresh and rosy complexion, was looking sallow and worn and very despondent. 3d. The facility of the operation was manifest, and my bimanual examination revealed all the peculiarities of the case before making the section. 4th. The very real danger of peritonitis and the possibility of the later discharge of the foetal parts by protracted suppuration. And further, I was acting in accordance with the practice of such eminent authorities as Lawson Tait and Olshausen who counsel early interference in all pelvic tumors where the probabilities of success are good. It must be remembered in any critique of the case that it present



features utterly unlike any other abdominal pregnancy ever recorded as operated upon. Dr. Harris's remarks will show that the crisis is not always past when the foetus is killed by electricity.

Dr. R. P. Harris said the case reported by Dr. Kelly had as clear a history of an extra-uterine pregnancy as we ever find in the *very early period* of ectopic gestation, when, it cannot be claimed, that a positive diagnosis can be made. We can, however, very closely approximate it, as was done prior to this operation. The woman had been twice normally pregnant; she ceased to menstruate on July 16, 1885, and there was no recurrence until November 17—a period of four months. She considered herself pregnant; and as the menstrual flow of November lasted a week, was excessive, and she passed, as she termed it, "two pieces of flesh," she thought she had aborted. Having seen her in the operation and upon several occasions since, I learned from her that her menstrual periods usually lasted about three or three and a half days, but had increased to a week or thereabouts after the return in November.

The development of the breasts, the presence of colostrum in them; the discharge of the deciduæ; the detection of the spherical tumor connected to the right cornu uteri; the decrease of this in size after the decidual expulsion, and the prolongation of the menstrual periods, all pointed to the existence of a right fallopian pregnancy and a dead foetus. When the tumor was brought into view in the operation, it was seen to be of a reddish-blue color, which is common to foetal cysts, and about three inches in diameter. When opened after removal, the placenta was found at the top, and the cyst empty of amniotic fluid, which had been removed by absorption. The foetus was a male, 5½ inches in length, and to judge by its size, degree of cranial ossification and mark of sex, it must have died near the end of the fourth month. Such a foetus, at the time of its death, must have occupied a cyst as large as a cocoanut. The loss of fluid in the cyst, made it sufficiently flaccid to admit of its being drawn upon so as to

form a pedicle for transfixion and ligation. Fortunately for the woman the cyst retained its integrity, the foetus perished, and there was no peritonitis to produce adhesions; the operation was therefore as simple as an early ovariectomy and no more dangerous.

There can be no question in my mind that under all the peculiar circumstances and advantages of this case it was proper to remove the foetal cyst for the purpose of relieving the pain felt in it, and of checking the menstrual loss. The question might be asked: Why operate in such a case, more than in one where foetal death has been produced by the faradic current? I answer, that under the same peculiar sufferings and advantages the execution might be called for. The after history of the cases of faradic foetocide has yet to be written. Thus far, there has been no death, immediate or remote, but there have been attacks of peritonitis, and there may be other troubles from the dead foetus after a long period. Very little has been recorded of the ill effects produced by ectopic foetuses, which have died in the second, third and fourth months of tubal or abdominal gestation. We know that a foetus of the fourth month has been passed whole from the rectum, and that one still smaller has been vomited, but death has rarely taken place within an unruptured cyst, in the second, third and fourth months, and we therefore do not know by the past, what may be likely to happen in some of the cases subjected to faradization. Thus far the method has much to recommend it, by its safety of application, and by the present health of its subjects. Foetal death being followed by absorption of the amniotic fluid, there is no longer any danger of the cyst rupturing from tension, and the woman's life is saved.

The first to destroy a foetus by electro-magnetism in the United States was our fellow member, Dr. Joshua G. Allen, who has now operated three times with success, and all of the women are still living.

CASE I, 1869, and CASE II, 1870, were illegitimately impregnated, and both have since married. Case I, remained

childless; she continued well for two or three years, and then went to the Jefferson College Hospital, where she was supposed to have rheumatism, but as the pain was in the lower part of the abdomen on the side corresponding with the seat of the foetal cyst, Dr. Allen attributes the attack of pain to the presence of the foreign body; the age of the foetus was computed at three months. In case II, the age was believed to be eight weeks, and the woman did well for a year or two, when she had an attack of peritonitis, lasting about three weeks. She subsequently married, bore a female child, now ten or eleven years old, had a second attack of peritonitis, about a year later, and four or five years later, a third. Although severe, Dr. Allen did not regard the attacks as dangerous to life.

Dr. J. C. Reeve's patient has had a probation of six years and has had no after trouble to note.

Dr. C. L. Billington writes me, that his patient has improved in health, and that although the foetus was computed to have a three months growth, "there was no tumor perceptible five or six months afterward."

*Dr. Lusk's* second operation was followed by a peritonitis which confined the patient to bed for two months. She is now near her maturity of pregnancy and has had no trouble during gestation from the presence of the tubal sac.

*Dr. Bache McE. Emmet's* case never showed the slightest effect from the presence of the ectopic foetus up to the last report, about a year ago.

*Dr. Garrigues* examined his patient two years after the operation, which was performed upon a foetus of "barely two months," and the "tumor to the right of the uterus had entirely disappeared." She had no longer any organs in sexual intercourse.

*Dr. P. F. Mundé* reports that at the end of two years his patient remains perfectly well.

In her menstruation, which was in progress when I last saw the patient of Dr. Kelly, the loss was restored to its normal moderation, and she was free from pain.

*Dr. Baer* spoke of a case of extra-uterine foetation which had gone to full term, and in which laparotomy was performed thirteen months after the death of the foetus. The mother had shown great loss of vitality, and the tumor felt loose in the abdominal cavity and promised to be easy of removal, but when the abdomen was opened, adhesions were found so numerous and strong that removal would not be safe. The opening in the sac was stitched to the abdominal wound. The temperature did not rise, and there was full recovery. This was an instance of tubal pregnancy carried to full term.

*Dr. Parish* said we would find, in the large majority of these cases, that at an early period, adhesions would be slight and removal easy. Operation after rupture of the cyst is not complicated by adhesions, except those forced by the placenta which are so vascular as to defy separation, and constitute the great danger. Prior to the fourth month, before such adhesions are formed, it is safe and easy to operate. It is a favorable time to operate after the death of the foetus, because the maternal tissues loose the extreme vulnerability that exists during the life of the child.

*Dr. Longaker* had been surprised at the absence of peritonitis after so much pain and tenderness.

*Dr. Kelly* remarked that the pain had always been non febrile, there had been no elevation of temperature or pulse.

There had, in this case, been no sense of contraction in handling the tumor as has been noticed in hydro-salpinx.

L. Tait had heard the uterine souffle in one case at his first examination, but could not find it again. Dr. Kelly has a case of extra-uterine foetation on hand now, and is waiting for the death of the foetus, when he will operate. Ohlshausen has formulated the rule that "any abdominal tumor as large as the fist should be removed."

A rich merchant, M. Chludow, has left more than £100,000 and a hoase to found a children's hospital in Moscow.—*The Lancet*, April 24, 1886.



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BALTIMORE, MAY 15, 1886.

Editorial.

THE RECENT MEETING OF THE AMERICAN MEDICAL ASSOCIATION.—Quite contrary to our anticipations, and more gratifying to wishes, the meeting of the American Medical Association, held in St. Louis during the past week, was characterized by peace, harmony and good feeling. The unfortunate questions which brought disgrace upon the meeting in New Orleans were not allowed to mar the interest and value of the meeting just held. The affairs of the Ninth International Medical Congress were left in the hands of the present Committee of Arrangements, the Association deeming it wise to take no further action in this affair. Whilst this course may have disappointed some, it was after all, perhaps, an indication of wisdom upon the part of the Association to have kept down any further discussion of the Congress controversy. We only regret that this rule of action was not adopted at New Orleans. The American profession would have been spared an immense humiliation and the success of the Congress would have been fully assured. The success of the Congress now devolves upon the present Committee of Arrangements created by the act of the Association at New Orleans. The Association has promoted Dr. N. S. Davis to the Presidency of the Congress, and Surgeon-General Hamilton, of the Marine Hospital Service, has been chosen Secretary-General.

To this combination, and to the Committee of Arrangements, the affairs of the Congress are entrusted. It remains to be seen whether the pledges made will be fulfilled. The profession has a right to hold these gentlemen responsible for the work they have assumed in this connection.

The Association has dodged the issue it raised one year ago, and has wisely, we think, placed the burden for the success or failure of the Congress upon the shoulders of those gentlemen who are responsible for the issue introduced at New Orleans. The St. Louis meeting was chiefly represented by Southern and Western delegates, and we assume that this representative element is prepared to back the President, Secretary-General and Committee of Arrangements with ample appropriations to meet the current expenses of the Congress, which have been roughly estimated at \$100,000. Since the profession in the East and North has been so generously treated in other respects in connection with the Congress it is taken for granted that they will be equally relieved of assessments and contributions to the treasury of the Congress fund. Having so nicely disposed of the affairs of the Congress the sessions of the Association were exceedingly amiable. The President in his address kindly complimented the Association on its ancient record, and then proceeded to offer suggestions and advice. His remarks were amiably received and the Special Committee appointed to consider his recommendations earnestly echoed his wishes in every particular. This committee expresses the wish of the President, "that the members of the profession cordially coöperate in the effort to make the American Session of the International Medical Congress creditable to the country and attractive and instructive to the foreign members, sacrificing personal and private piques and disappointments in generous emulation to contribute to that success which has been unconditionally pledged in the invitation tendered to the foreign members of the Congress to meet in the United States." Apart from this unctuous advice the President and Special Committee

have nothing to say in reference to the Congress. Perhaps it was just as well to draw the line here.

In the various Sections the usual routine work of reading papers and of discussions on the same was faithfully carried out. These papers were contributed in a number of instances by men who have not taken part in any previous meeting of the Sections. This may be considered a hopeful sign. The Association has long needed the vivifying influence of fresh blood. We are glad to see new names backed by titles of new subjects in the work of the Sections. The West and Southwest responded quite handsomely in the work before the Sections. This is another favorable sign. It shows that the representative character of the Association has extended to the fertile plains of the great West and Southwest and that in the future we may have other good products from these regions as well bread-stuff and live-stock. The Congress controversy has had one excellent effect already; it has shown the East that much dormant talent has been buried under the profuse foliage of the Mississippi Valley. Our Western brethren have "out Heroded Herod." They have handed up a handsome offering to the annual work of the Association. It may be said they have captured the Association in body and soul, just as surely as they have captured its official organ. Dr. E. H. Gregory, of St. Louis, has been chosen President, and Chicago is to be the next place of meeting. The sentiment of the meeting was thus expressed, the East and North must take a back seat, this is a representative Association, but it must represent the West. So long as the empire of progress westward bends her sway, why should not the empire of medicine do likewise? This is good logic, and our Western brethren think it eminently good practice. We should be glad to turn the Congress over to our Western friends. We are assured of one thing, it would be a "smiling" success, an improvement on the method inaugurated by the late Governor of North Carolina and extended in most neigh-

bourly hospitality to his friend across the border.

The St. Louis meeting may be characterized as the "Peace Meeting." Brotherly love and hospitality were poured out upon the irreconcilables. "How pleasant it is to dwell together in unity" was indoctrinated into the delegation, and all returned home to prepare for the great love-feast in Washington in 1887. The Association is indebted to the amiable and hospitable efforts of the St. Louis profession for this happy and peaceful adjustment of her internal disturbances. She should long commemorate the St. Louis jubilee as one of the happy incidences in her checkered career.

**THE BLOOD PLAQUE.**—The much studied third corpuscle of the blood seems to have at last reached a firm physiological position, and to have earned recognition at the hands of most investigators. The fact of its existence in the blood, the relation it holds to the other corpuscular elements, and especially the part it seems to play in the process of coagulation, will necessitate change in our views of many processes which have been regarded as settled. By far the most important part of Professor William Osler's Cartwright Lectures "On certain problems in the physiology of the blood corpuscles," is that which is devoted to the consideration of this subject. Various names have been suggested for the corpuscle as *globulins* (Donné) *elementary corpuscles* (Zimmerman), *granular debris*, *granule masses* (Schultze), among the earlier investigators, and *third corpuscle*, *hematoblast* and *blood plaque* among the more recent. "Blood plaque" is a translation of Bizzozero's *blutpattchen* adopted by Kemp of the Johns Hopkins' Laboratory, and approved by Prof. Osler as a suitable name, and at the same time a proper tribute to Bizzozero, who has done so much to draw attention to the subject. The blood plaque is described as "a colorless protoplasmic disc, constant in mammalian blood, measuring from 1.5 to 3.5 micromillimeters. The number, per cubic millimeter, in the blood



of a healthy adult, is about 250,000, but their number varies greatly at different periods of life, and with varying conditions of health and disease. The ratio to the red is about 1 to 18 or 20." They are very abundant in the new-born, comparatively scanty in the adult, and again more frequent in old age, especially if associated with wasting disease. The relation of the plaques to disease has not been sufficiently observed to justify full and definite conclusions. Professor Osler's own studies lead him to the conviction that they are very much increased in number in chronic wasting maladies with or without fever, phthisis, cancer, &c., and in the later stages of acute systemic fevers, when the patients have become debilitated. In the so-called blood diseases their number is variable. Many observers are of the opinion that the plaques are the result of the disintegration and degeneration of the other blood corpuscles. Hayem believes they are young red corpuscles—hence the name "hæmatoblasts," which he suggested for them—but the majority of investigators regard them as independent elements of the blood whose origin and properties have not as yet been sufficiently studied. The relation of the plaque to blood formation is still under investigation, and most diverse views have been advanced. Hayem's hæmatoblastic theory has met with much opposition. The fact that plaques are most abundant when corpuscular production is most rapid, viz: in the new born, after hæmorrhages, and in convalescence from acute diseases, is strong in its favor. So also the large number of plaques in wasting processes is explained by an inability to reach full development. Afanassiew holds that the plaque develops into a nucleated red corpuscle, the nucleus of which is in turn extruded and becomes a plaque. Those who have worked most on this subject are however not prepared to accept, with any degree of unanimity, any theory yet propounded. The study of coagulation has shown much of great interest with reference to the part played by the plaques in that process. Schultze and Ranvier noticed thirteen years ago that

as the process of coagulation was watched under the microscope, the fibrine filaments radiated from the granular masses, now known to be aggregations of plaques. These fibrin needles form also independently of plaques, but the granular masses are the centres about which they are most abundant. This tendency to adhere in masses is characteristic of the plaques and explains the part they play in certain conditions. They are found by experiment to compose almost exclusively what are known as white thrombi, they are the first elements of the blood which adhere to a foreign body as a needle or bit of cotton placed in the stream of blood, and they coat over the margins of a wound in a blood vessel. The experimental researches of Bizzozero, Eberth, Hayem, Langhaus and Osler have elicited many facts at variance with our earlier teaching, and if their results are corroborated by others, as seems probable, this comparatively recent new comer will make as great a stir among the pathologists as it is now making among the physiologists.

### Reviews, Books and Pamphlets.

*A System of Practical Medicine.* By American Authors. Edited by WM. PEPPER, M.D., LL.D., and LOUIS STARR, M.D. Volume IV. Diseases of the Genito-Urinary and Cutaneous System.—Medical Ophthalmology and Otology. Philadelphia, Lea Brothers & Co., 1886. P. 841.

*The Surgical Diseases of Children.* BY EDMUND OWEN, M.B., F.R.C.S., Surgeon to the Hospital for Sick Children, Great Ormond Street, London. 12mo., 585 pages, with 4 chromo-lithographic plates, and 85 engravings. Cloth, \$2. Philadelphia, Lea Brothers & Co., 1886.

*A Manual of Surgery.* In Treatises by Various Authors. In three volumes, edited by FRANK TREVES, F.R.C.S., Surgeon to and Lecturer on Anatomy at the London Hospital. Vol. I., General Surgical Affections, The Blood-vessels, The Nerves, The Skin. Vol. II., The Thorax, The Organs of Digestion, The Genito-Urinary Organs. Vol. III., The Organs of Locomotion and of Special Sense, The Respiratory Passages, The Head, The Spine. Duodecimo, 1866 pages, 213 engravings. Per volume, cloth, \$2. Philadelphia, Lea Brothers & Co., 1886.

*Surgical Diseases of the Kidney.* By HENRY MORRIS, M.A., M.B., F.R.C.S., Surgeon to and Lecturer on Surgery at the Middlesex Hospital, London. 12mo. 555 pages, with 6 chromo-lithographic plates and 40 engravings. Cloth, \$2.25. Philadelphia, Lea Brothers & Co., 1886.

*Practical Human Anatomy.* A Working-Guide for Students of Medicine and a Ready-Reference for Surgeons and Physicians. By F. D. WEISSE, M.D., Professor of Practical and Surgical Anatomy, Medical Department of the University of New York. Illustrated by 222 lettered plates, containing 321 figures. New York, William Wood & Company, 1886.

*The Genuine Works of Hippocrates.* Translated from the Greek with a Preliminary Discourse and Annotations. By FRANCIS ADAMS, LL.D., Surgeon. In two volumes. Vol. I., Wood's Library Series, for 1886. New York, William Wood & Company, 1886. Pp. 390.

*Diseases of the Spinal Cord.* By BYRON BRAMWELL, M.D., F.R.C.P. (Edin). Second Edition. Illustrated with 53 colored plates and 102 fine wood engravings. Wood's Library Series for 1886. New York, Wm. Wood & Company, 1886. Pp. 286.

*Easy Lessons in Sanitary Science.* By JOSEPH WILSON, M.D. Second Edition, with Important Additions. Philadelphia, P. Blakiston, Son & Co., 1886. Pp. 72.

*The Menstruation Disorders.* A Practical Treatise. By JOHN N. UPSHER, M.D., Professor of Mat. Med. and Therapeutics in the Medical College of Virginia. New York, G. P. Putnam's Sons, 1886. Pp. 195.

*The Principles and Practice of Surgery.* By FRANK H. HAMILTON, A.M., M.D., LL.D., Late Professor of the Practice of Surgery in Bellevue Hospital Medical College. Third Edition, Revised and Corrected. New York, Wm. Wood & Company, 1886. Pp. 964.

*Diseases of the Digestive Organs in Infancy and Childhood,* with Chapters on the Investigation of Disease, and on the General Management of Children. By LOUIS STARR, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. With colored plates and other illustrations. Philadelphia, P. Blakiston, Son & Co., 1886. Pp. 373.

*A Manual of Midwifery.* By ALFRED LEWIS GALABIN, M.A., M.D., Obstetric Physician and Lecturer on Midwifery and the Diseases of Women to Guy's Hospital, etc. Illustrated with 227 wood engravings. Philadelphia, P. Blakiston, Son & Co., 1886. Pp. 740.

*Hand-book for the Instruction of Attendants on the Insane.* Boston, Cupples, Upham and Company, 1886. Pp. 137.

*The Students Manual of Venereal Diseases.* By BERKLEY HILL, M.D., and ARTHUR COOPER, M.D. Fourth Edition. Revised. Philadelphia, P. Blakiston, Son & Co., 1886. Pp. 132.

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*Hand-book of Practical Medicine.* By Dr. Herman Eichhoost, Professor of Special Pathology and Therapeutics and Director of the University Medical Clinic in Zurich. Volume I. Diseases of the Circulatory and Respiratory Apparatus. 103 wood engravings. Wood's Library Series, 1886. New York, Wm. Wood & Company, 1886. P. 402.

## Miscellany.

STRYCHNINE IN UTERINE HÆMORRHAGE.—F. H. V. Grosholz writes to the *Brit. ish Med. Journal*, (March 13,) "Though I have not made any trial of a course of strychnine for pregnant women, to prevent the occurrence of hæmorrhage in labour, I have for the past ten years been constantly in the habit of administering it to arrest *post partum* hæmorrhage.

"My favorite combination to produce regular uterine contraction in these cases is a mixture containing fifteen minims of tincture of nux vomica, fifteen minims of tincture of opium, and half a drachm of ammoniated tincture of ergot. I have almost invariably had most satisfactory results with this dose. Nux vomica, through its alkaloid strychnine, has the direct and almost immediate effect of producing muscular contraction—especially strong in paralysed parts—and also of retarding the circulation; nor is it improbable that the exaltation of the nervous system produced by its administration renders the action of the ergot more prompt and effectual. The object I had in view in adding the opium was mainly to prevent irregular or spasmodic contraction of the uterus, and also to allay the excitement frequently present in these cases. I have found the preparation of ergot here mentioned particularly reliable, and its stimulant effect is of decided advantage. In abortions and miscarriages, I have also had satisfactory results from the administration of this mixture, given frequently and in smaller doses."

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION FOR THE ENSUING YEAR.—The *Committee on Nominations* reported as follows: For president, E. H. Gregory, of Missouri; for first vice-president, E. H. Miller, of Minnesota; for second vice-president, W. B. Welch, of Arkansas; for third vice-president, W. H. Pancoast, of Pennsylvania; for fourth vice-president, W. C. Wile, of Connecticut; for permanent secretary, W. B.



Atkinson, of Pennsylvania; for assistant secretary, J. N. Hyde, of Illinois; for treasurer, R. J. Dunglison, of Pennsylvania; for librarian, C. H. A. Kleinschmidt, of the District of Columbia.

*Committee on Necrology.*—Chairman, J. M. Toner, of the District of Columbia, and one member from each State.

*For Officers of Sections:* State Medicine.—Chairman, G. A. Kitchen, of Alabama. Obstetrics and Gynecology.—Chairman, S. M. Johnson, of Kansas; secretary, W. W. Jaggard, of Illinois. Practice of Medicine.—Chairman, John S. Lynch, of Maryland; secretary, F. Marvin, of Kentucky. Surgery.—Chairman, H. H. Mudd, of Missouri; secretary, J. H. Roberts, of Pennsylvania. Oral and Dental Surgery.—Chairman, J. S. Marshall, of Illinois; secretary, E. S. Talbot, of Illinois. Judicial Council.—Chairman, N. S. Davis, of Illinois; H. Brown, of Kentucky, W. Brodie, of Michigan, R. J. Roberts, of Tennessee, R. C. Moore, of Nebraska, E. A. Foster, of Maine, and J. A. Gray, of Georgia. Trustees of the Journal of the Association.—P. O. Hooper, of Arkansas, A. Garcelon, of Maine, and L. S. McMurty, of Kentucky. Chairman of the Committee of Arrangements, Chas. G. Smith, of Illinois. The next meeting to be held in Chicago, the first Tuesday in June, 1887.

**PROPOSED MODIFICATION OF PIROGOFF'S OPERATION.**—At the recent congress of Russian practitioners, Professor Tauber described and demonstrated on the dead subject an operation for removal of the foot, which he believes has several advantages over Pirogoff's amputation. Standing on the outer side of the limb, he commences an incision at the insertion of the tendo Achillis, and carries it forward just below the external malleolus to the dorsum of the foot, and then vertically downwards on the inner side in front of the heel. When the middle line of the sole is reached, the incision is carried along it backwards and prolonged upwards to the starting-point at the insertion of the tendo Achillis, a flap having thus been cut consisting of the inner side and half the sole of the

heel. The joint is then opened, the external ligament being first divided and then the internal. The astragalus is seized with the bone forceps and removed, nothing being left but the os calcis, the soft covering of which on the inner aspect is untouched. The os calcis is seized with the bone forceps and turned so that the articular surface is towards the operator. The forceps are now taken by an assistant, who holds them tightly; the operator then saws the bone longitudinally in two; the outer half, which is free, is removed, the inner half remaining attached to the flap. The ends of the tibia and fibula are then sawn off just above the malleoli. The cut surfaces of these will be found to correspond almost exactly with that of the os calcis, which is now brought into apposition with them. The advantages claimed for this operation are: 1. The posterior tibial artery itself is untouched, only its branches being divided. 2. The insertion of the tendo Achillis, as well as its bursa, are not injured. 3. The surfaces of the os calcis and of the leg bone correspond very nearly to one another.—*Lancet*, April 3d, 1886.

**SCIRRHUS OF THE BREAST: SO-CALLED "LONG RECURRENCE."**—Mr. Herbert Snow says in the *British Medical Journal*, (March 27, 1886,) "I have long felt convinced that, in speaking of recurrences of breast cancer many years after operation, we commit an egregious fallacy of weighty import in its practical bearings. The second deposit will always be found to have an entirely novel causation, and so to be altogether a new departure, quite independent of the previous attack. The following case well illustrates this fact. I may add that if, two years after excision of the diseased breast, with the contents of the corresponding axilla, a step which should hardly ever be omitted, the patient can pass a careful medical scrutiny, and be pronounced free from all recurrence, experience leads me to consider her permanently cured.

Sarah C., aged 58, admitted to the Cancer Hospital March 14th, 1886. Eleven years ago, the left breast was re-

moved at the London Hospital, by Mr. Jonathan Hutchinson, for cancer of nine months' duration. The patient remained well till five months since; then fell, striking the side against a table. The present tumor appeared a few weeks afterwards. On admission, the old cicatrix was found perfectly healthy, and freely movable. Between its inner end and the sternum was a scirrhus growth, deeply seated, as large as a walnut; the right axilla contained a cluster of enlarged glands."

### Medical Items.

Sir William Jenner has been re-elected President of the Royal College of Physicians.

The *Weekly Medical Review*, of St. Louis, displayed a commendable enterprise in issuing a daily bulletin giving a report of the sessions of the American Medical Association.

The eighth annual Congress of the American Laryngological Association will be held in the Hall of the College of Physicians of Philadelphia, on Thursday, Friday, and Saturday, May 27, 28, and 29, 1886.

Dr. E. T. Reichert, formerly Demonstrator of Physiology in the University of Pennsylvania, has been elected to the Chair of Physiology in that institution. Dr. Reichert delivered the course of lectures in this branch in the session of 1885-86, vice Professor Harrison Allen, resigned.

Dr. James S. Mackenzie, a well-known physician, of this city, died May 10th, at his residence, No. 67 Franklin Street. He was ill only a few hours, his death being due to heart disease. Dr. Mackenzie was 66 years of age. He was a son of Dr. Colon Mackenzie and a member of a family largely represented in the medical profession. He was a graduate of Jefferson Medical College, Philadelphia.

Rapid progress is being made with the new buildings of the London Hospital Medical School, and there is no reason to doubt but that they will be ready for use at the opening of the winter session next October. No pains or expense have been spared to make the new building complete in every department; and it is said that, when finished they will form the largest school-building in London.—*British Medical Journal*.

Dr. Edward Curtis tendered his resignation as Professor of *Materia Medica* to the Faculty of the College of Physicians and Surgeons, of New York, on Wednesday. He had informed the Faculty some time ago of his intention to resign at the end of his term, and as they had secured Dr. George L. Peabody to

be his successor, his resignation was accepted. For fourteen years Dr. Curtis has been a Professor in the College, and his work had been appreciated by students and Faculty. His resignation was caused by the pressure of outside business. As medical director of the Equitable Life Assurance Society, the greater part of his time and attention is called away from his College duties. Dr. Peabody will assume his new duty in October.—*Medical News*, May 1st, 1886.

The American Surgical Association held its seventh annual session in Washington, D. C. on April 28, 29, 30 and May 1st. Papers were read as follows: "Diagnostical Laparotomy," by Christopher Johnston, M.D., of Baltimore; "A Consideration of the Bacteria of Surgical Diseases," by Harold C. Ernst, M.D., of Jamaica Plain, Mass.; "A Plan for Atmospheric Purification for Surgical and for Hygienic Purposes," by David Prince, of Jacksonville, Ill.; "Cholecystotomy," by C. T. Parkes, of Chicago; "The Surgery of the Pancreas, As Based Upon Experiments and Clinical Research," by N. Senn, of Milwaukee.

The following officers were elected for the ensuing year: President, Hunter McGuire, M.D., of Richmond; vice-presidents, T. F. Prewitt, M.D., of St. Louis, and J. W. S. Gouley, M.D., of New York; secretary, Jacob R. Weist, M.D., of Richmond, Ind.; treasurer, P. S. Conner, M.D., of Cincinnati; recorder, J. Ewing Mears, M.D., of Philadelphia; council, Drs. Moses Gunn, of Chicago; R. A. Kinloch, of Charleston; Hunter McGuire, of Richmond; John S. Billings, of Washington, D.C.; and L. McLane Tiffany of Baltimore. Place and time of next meeting, Washington, D. C., second Wednesday in May, 1887.

At the recent meeting of the American Medical Association, Dr. A. Y. P. Garnett of Washington offered the following resolution, which was adopted: "That the delegates to this Association be requested, on returning to their homes, to adopt such means as may to them seem best to call the attention of their respective representative in the Congress of the United States to the desirability of making an appropriation of money to assist in heartily receiving and entertaining the International Medical Congress in 1887."

Dr. N. S. Davis introduced the following amendment to the By-Laws. Section two, paragraph three, shall be amended so as to read: "On the second day of each annual meeting, each Section shall nominate its own officers to serve for the next ensuing year; their duties to commence with the close of the annual meeting at which they are nominated, and to continue until their successors are elected." The proposed amendment gave rise to discussion. A rising vote was taken, and the President declared the amendment adopted by a four-fifths vote. The Association also adopted the following resolution, "That cremation has become a sanitary necessity in all highly populated Countries, and this Association advises its adoption so far as practicable."



## Original Articles.

## THE INFLUENCE OF PREGNANCY AND PARTURITION UPON ORGANIC CARDIAC DISEASE.\*

BY T. A. ASHBY, M.D.

Professor of Obstetrics in the Woman's Medical College of Baltimore, Etc.

During gestation the heart is called upon to perform increased duty in maintaining the circulation of an increased volume of blood, an increased arterial tension, and in distributing the blood-supply into new and rapidly-developing vessels and tissues. As a result of this assumption of greater exercise and frequency of ventricular contraction hypertrophy of the left ventricle is constantly found in the pregnant woman. The heart is prepared in a physiological way for the extra duty exacted of it, and it continues to perform this duty until the influence of pregnancy is withdrawn. Of the various modifications imposed upon the female organism by pregnancy none is more astonishing than the functional activity of the heart under the influence of gestation and parturition. The test of cardiac soundness seems to be thoroughly tried. If any defect exists in the circulatory apparatus it is most likely to be made manifest under the trial to which it is subjected. Assuming that a healthy circulatory system is required to meet the extra strain and ordeal of pregnancy and labor, we should expect to find organic heart disease unfavorably influenced by these conditions, and especially by the latter function, as the disturbances of the heart's action are more pronounced under the ordeal of severe exercise than at any other time. Under the influence of uterine contraction the large volume of blood distributed to the uterus is suddenly thrown back into the general circulation and must be provided for by vaso-motor influences. Alternate contraction and relaxation take place with

great suddenness, and unless the compensatory laws which preside over the entire circulatory system work with promptness and energy disturbances of a more or less serious character are unavoidable. The equilibrium of the circulation must be maintained by the promptness with which the heart and blood-vessels—arteries, veins and capillaries—adjust their action to the rapid change of conditions which occur in labor. Aside from the profound moral impression which labor makes upon the majority of parturient women, the physical exertion and the sudden disturbances of the blood-supply to the uterus call for the expenditure of great energy and force upon the part of the heart and its vessels, a force which is not easily measured by any other standard of exercise to which woman is subjected.

When the heart is prevented by disease from adjusting itself to the conditions mentioned variable influences will be experienced. The extent of these influences must depend upon the character of the organic changes, or upon the character of the labor. It is well-known that patients suffering from serious organic disease pass through the ordeal of labor triumphantly. The compensatory action of the heart, if disturbed at all, is fortunately adjusted, and delivery takes place it may be, with no alarming symptoms. If such be the happy termination of labor in even the majority of cases suffering from organic cardiac disease, it is not the invariable rule. The late Dr. Angus Macdonald, some years ago collected 28 cases of pregnancy complicated with cardiac disease, of which 17 died during labor. Macdonald's observations led him to formulate the opinion that the evils resulting from pregnancy in connection with cardiac disease are due to two causes: first, destruction of the equilibrium of the circulation which has been established by compensatory arrangements; secondly, the occurrence of fresh inflammatory lesions upon the valves of the heart already diseased.

Spiegelberg attributed the grave symptoms of mitral disease presenting

\*Read before the Gynecological and Obstetrical Society of Baltimore, May 11th 1886.

themselves during labor, or soon after confinement, to excessive distention of the right heart with blood forced from the contracted uterus. Fritsh opposed this idea and attributed the morbid phenomena of mitral disease to the accumulation of blood in the abdominal vessels recently released from the pressure of the gravid uterus, and to the cardiac paralysis resulting from an insufficient blood-supply and consequent defective nutrition of the heart.

The influence of pregnancy and labor upon the circulatory apparatus may be viewed from three standpoints: 1st, the influence exerted upon the heart and blood-vessels affected with organic disease prior to pregnancy; 2nd, the influence exerted upon the heart's valves and upon the heart's action during uterine contraction; 3rd, the permanent damage which the heart sustains from the influence of pregnancy and labor.

It is proposed to consider these conditions in the briefest manner, as the discussion of this subject can not be elucidated by any important clinical facts within our possession. We must draw surmises rather than offer data to establish conclusions.

1st. The influence of pregnancy and labor upon organic cardiac disease may be considered as unfavorable. A heart already crippled by disease is poorly prepared for the increased exercise and disturbing influences of labor. The heart is called upon to put forth unusual effort during uterine contraction in consequence of the irregularity of the blood-supply to the uterus and pelvic organs. The entire circulatory apparatus is required to function under extraordinary conditions, and any weak point in the construction of this circulatory apparatus is exposed to imminent danger. If the heart itself is at fault, the damage will be inflicted upon it, resulting in impaired or suspended action, or if the defect reside in artery, vein or capillary, rupture of one of these vessels may be the result with circumscribed or general extravasation of blood into surrounding tissues; cerebral hæmorrhage, pelvic hæmatocele, or effusions of blood into cellular tissues, are not unknown

results of the influence of labor upon the vascular system.

2nd. The influence exerted upon the valves of the heart and upon the action of the heart during uterine contraction is extremely variable. As the general rule the heart valves are capable of sustaining the increased tension thrown on them by uterine contraction. The right heart may, however, become over-distended and the phenomena of mitral disease may manifest themselves. We have elsewhere stated the opposing views of Spiegelberg and Fritsh in regard to this question. It seems to us that there is truth in both of these theories, and that over-distension or insufficiency of the blood-supply to the heart may both equally well account for the phenomena of cardiac irregularity or paralysis. The heart's action may undoubtedly become tumultuous, labored or disturbed by the diminution, or by the increased pressure, of the blood-supply. The exceedingly rapid action of the heart following violent post-partum hæmorrhage is an explanation of the effect of diminished blood-supply to the cavities of the heart. It can make but little difference whether the blood-supply is simply diverted and thrown into the pelvic vessels, as suggested by Fritsh, or whether it is lost by escape from the uterine sinuses; the temporary effect upon the heart must prove the same. Over-pressure of the blood-column upon the heart's valves might be sufficient under extreme conditions of arterial tension to induce temporary or even permanent insufficiency, or a rupture sufficient to destroy cardiac action at once.

3rd. Permanent damage to the heart and vascular system is not an impossible result of the influence of pregnancy and labor. The physiological hypertrophy of the left ventricle is undoubtedly compensatory, and, so far it goes, actually improves the circulation; but whilst this may be necessary to maintain an increased blood-pressure and arterial tension under ordinary circumstances, it is probable that under certain conditions permanent enlargement and even dilatation of the heart may persist after



gestation. As a result of the extra strain of pregnancy valvular inflammation may supervene and permanently impair these structures by plastic deposits or by ulceration. During labor the pressure exerted upon the valves may likewise result in permanent incompetency. There may therefore persist a stenosis or incompetency of either the mitral or aortic valves.

There is no clinical evidence, however, in our possession to establish these conclusions, but they seem tenable on purely anatomical and pathological grounds.

Where organic lesions exist prior to pregnancy the case is different. The influence of pregnancy and labor can scarcely do otherwise than promote further pathological changes even though the ordeal of labor is successfully passed through.

Macdonald takes an unfavorable view of the prognosis of labor associated with cardiac disease. His statistics show a mortality of 60 per cent. He was so impressed with this idea that he considers marriage contra-indicated when cardiac disease is known to exist. This suggestion, if acted upon by those who have knowledge of the existence of cardiac disease, would, no doubt, do away with not a few of the serious complications of child-bearing.

The dangers of wedlock should at least be explained to such persons by the family physician whose advice is often sought, if not always accepted by his patients. Should cardiac trouble be recognized after pregnancy has been established the existence of a diseased heart should arouse the obstetrician's interest and anxiety. The ordeal of labor is not to be considered with levity if the history of the following case is in keeping with the usual behavior of such cases.

During the latter half of the month of December, 1880, Mrs. M. called at my office and engaged me to attend her in her approaching confinement. She was between six and seven months advanced in her second pregnancy. The appearance of my patient made an unfavorable impression upon me, and I made close inquiry into her condition. She was tall, slender and anæmic, and was below par in

general health. She had suffered with distressing nausea, weakness and anxiety during gestation, and expressed serious forebodings of her approaching confinement. I found, upon physical examination, that both the mitral and aortic valves of her heart were defective. She had a decided mitral regurgitant and an aortic obstructive murmur. The heart was hypertrophied. It was performing its duty with regularity and force. Pulse good; no œdema or dropsy. Her condition was one of general debility, anæmia and nervous excitement. I saw this patient several times during the next few weeks, and gave her such instructions in regard to her confinement as were deemed advisable in the way of prophylaxis.

On the night of February 28th, 1881, I was hurriedly called to attend this patient in labor. Being absent from my office at the time, it was over a half-hour before the message reached me. I hastened to the patient's bedside, and, upon entering her room, found her in the most alarmed and excited condition. She was tossing herself from one side of her bed to the other, throwing her arms about in confusion, and crying "help!" "I am dying!" "Do save me!" and other wild and terrifying exclamations. I soon restored a degree of quietude, and made an examination. The child had been delivered fifteen or twenty minutes prior to my arrival, but the placenta had not come away. Introducing my finger into the vagina, I found the placenta firmly attached to the upper left segment of the uterus. I removed it with some difficulty. The uterus at once contracted firmly, and hæmorrhage ceased. Ergot and brandy had been given hypodermically. The amount of blood lost prior to my arrival was considerable. I estimated it at between 16 and 20 ounces. There was no bleeding after the detachment of the placenta, and, as far as I could determine, the amount of blood lost was not sufficient to account for the great depression and alarming condition of my patient. The firm contraction of the uterus and suspension of the flow of blood failed to exercise any beneficial influence upon the patient. Her nervous, excited and alarmed frenzy broke out with renewed violence, and in spite of every injunction she would not be quieted nor comforted. Her circulation may be described as horrible. The heart was beating with great violence, irregularity and excitement. Its action was thumping and tumultuous. It vainly and vigorously attempted to expel the flow of blood emptied into its cavities, but with such poor success that pulmonary congestion was soon established, respiration was hurried and embarrassed, and dyspnoea was becoming alarming. The circulation at the wrist, and in the lower extremities, was barely perceptible, though the heart beat was heard some inches from the thorax. The heart continued this irregular, tumultuous beat until about 1 o'clock, A. M., when suddenly its action suspended, and my patient died with the exclamation on her lips, "I am dead!"

The closing scene of this drama is better remembered than described. It suggested the

total inability of human skill to establish a normal condition when organic disease has entered in to complicate a physiological function.

Reviewing the symptoms observed in this case, I was convinced then, as I am at the present day, that the post-partum hæmorrhage was not sufficient in itself to have accounted for the death of my patient. I doubt not the hæmorrhage was an important factor in the disturbance of the heart's action, but had this organ been in a condition to perform its physiological function, the loss of blood sustained would have imposed no severe hardship upon this patient. Organic disease had so impaired the working power of the heart that the moment extra effort was required of it to preserve the equilibrium of the circulation, it broke down in the performance of its duty and failed to adjust itself to the requirements of the situation.

### HYSTERECTOMY FOR REMOVAL OF A FIBRO-CYSTIC TUMOR.\*

BY ROBERT T. WILSON, M.D.,

Assistant Surgeon to the Hospital for the Women of Maryland, of Baltimore City, Gynæcologist to the Union Protestant Infirmary.

It will be remembered that at the meeting of the "Obstetrical and Gynæcological Society of Baltimore City," held January 12th, I exhibited a specimen of a very large fibro-cystic tumor, which I removed the day before from a woman at the Union Protestant Infirmary. I then promised to give you a history of the case and of the operation at a future meeting, and I am here this evening to fulfill that promise. I also desire to show to you, by a photograph, which I made myself, the appearance of the abdomen before the operation.

In January, of this year, Mrs. J. M. came under my care at the Union Protestant Infirmary. Upon questioning her, I found that she was forty years of age, and born in this State. She first menstruated at eleven years of age, and it has come on regularly every four weeks ever since, each period lasting four to five days, but not too free, and having no pain to speak of. Five years ago she weighed one hundred and sixty-three pounds; and three years ago she

noticed that she was losing flesh all over her body, but in the abdomen, where she felt weighty and had a heaviness. The abdomen has been increasing in size for the past two years. In June last she measured around the abdomen thirty-eight inches, and in July forty inches.

During the past two years, she has suffered with dragging and bearing down feelings in the back, and pains frequently shooting through back and abdomen. At times she would pass a very small quantity of urine. Bowels generally regular. Two years ago, and also last summer, she laced tightly. She did so, because she was told to do it, and not that she felt better from it, for she noticed no change in her feelings. Only from worry would she have headaches. She has been married twenty years, but has had no children. Her countenance showed the lines of care well depicted upon it; the "facies ovariana" was observed. She was confident that each day she was getting larger in the abdomen, and her strength daily lessening she said she must be helped, and if there was a chance for her to be relieved of the tumor she would like to have it removed, as she felt that she could not last longer as she was, her sufferings having increased the past four or five months.

Upon examining the abdomen I found dullness on percussion over the whole abdomen; uncertain and indistinct resonance on percussion in the left lumbar region; clearness in the right; below the umbilicus, and to the left side, upon palpitation, fluctuation was distinctly felt. By digital examination, per vaginam, pelvis was clear, and the uterus measured three inches in length. From this examination and the size of the tumor being so great, and its growth within the last few months being so rapid, surgical interference became imperative. So on the 11th of January, the patient being etherized by Nathan R. Gorter, M.D., I made an incision four inches in length in the median-line, beginning two inches above the pubes. As soon as the cavity was opened there was a great discharge of bloody serum. Pressure upon the tumor by the finger also gave the sensation of fluid within.

\*Read before the Baltimore Gynæcological and Obstetrical Society, May 11th, 1886.



The trocar (Well's) was pushed into the tumor, but only a little blood escaped. The incision was enlarged to six inches and further exploration made with the hand, when it was found to be a tumor in which the uterus and ovaries were involved.

The incision was carried above the umbilicus, the length of incision then being eleven inches.

The tumor grew from the whole back part and side of the uterus; it was attached to the left iliac fossa and left brim of pelvis, and left side of the abdominal walls back to spinal column. It was attached also to the omentum, intestines and bladder.

The omentum could be peeled off, but its vessels were very large, so that in many places it had to be ligated and cut from the tumor in sections.

The intestines were situated behind and above the tumor.

The tumor at its lower part projected prominently forward over the symphysis pubis, and evidently contained fluid at this point, so that I was in doubt whether it was a cyst or the bladder distended with urine.

This point was cleared up by passing a sound into the bladder, which accurately outlined the extent of its attachments to the tumor and with the sound as a guide, I punctured the cyst and evacuated from this part of the tumor a pint of transparent straw-colored fluid, which spontaneously coagulated, and the sac only in part collapsed. With great difficulty the bladder was separated from the tumor, but numerous bleeding points had to be ligated before the oozing from its surface was controlled. By hard pulling and pushing, the huge mass was slowly drawn forwards, as far as its connections to the back and left side of pelvis would permit. The intestines were carefully peeled off from the tumor. The attachments were so dense and vascular that they could only be separated by gathering them up in sections, applying double ligatures, and cutting between, so that when the tumor was freed from its pelvic and abdominal adhesions there were thirty-three ligatures left in the abdominal cavity. During the operation, she lost very little blood.

As all vessels were clamped or ligated as soon as the tumor was freed, I placed Keith's-hysterectomy clamp around the uterus, just above the vaginal junction, and cut away the mass. Three drainage tubes were introduced, one to the bottom of the pelvis, and others at different points in the abdominal cavity. The reason for introducing so many drainage tubes was on account of the great amount of bloody serum that poured out from the surfaces of the extensive adhesions.

The stump was closely trimmed off, and the portions above the clamp touched with liq. ferri sub. sulph. The wound was closed with nine silver wire sutures, and iodoform freely sprinkled around the stump, the usual dressing applied, and the patient placed in bed.

Just before the operation she was given, by the mouth, a tablespoonful and a half of whiskey in some water. The heart's action not being good, ether was the anæsthetic given. Her pulse, under the ether, in the beginning was 100, and very feeble. And during the operation it was necessary to give her repeated hypodermics of whiskey, and she received by this means 5xvi (m. 960). A syringe was used which holds m. 75.

During the operation her body was kept warm by hot bottles and blankets. The operation lasted one hour and twenty-five minutes. She never reacted, and died in twenty-six hours from shock. Much bloody serum flowed from the drainage tubes, and the abdominal cavity was washed out several times with bichloride of mercury, sol.  $\frac{1}{1000}$ , the fluid being thrown in through one tube and flowing out freely through the others.

Previous to operating the urine was chemically examined, and was found to be acid in reaction; color deep amber hue; specific gravity 1020; slight amount of albumen (heat and nitric acid tests); measurement around the body forty-six inches.

The tumor weighed thirty-one pounds after much bloody serum had drained away from it. The tumor was placed in the hands of Dr. Wm. T. Councilman, of the Johns Hopkins University, for examination, and I herewith read you his report:

JOHNS HOPKINS HOSPITAL,  
BALTIMORE, January 27th, 1886.

Dr. Robert T. Wilson:

DEAR SIR—The following is the result of my examination of the specimen you sent me. The smaller mass, which presented the appearance of a bifid uterus was found to be a portion of the uterine canal with a large myoma on either side. These were the size of small oranges, and one was degenerated in the centre. The large mass was smooth on the surface, and gave unmistakable fluctuation. Attached to the surface was a fallopian tube and a corner of the uterus. The tube was elongated and dilated.

On section the tumor presented a fibrous appearance, was very oedematous and contained numerous cysts of various sizes. These cysts did not communicate with one another, and were filled with a clear straw-colored fluid. Some of them contained attached to their walls large masses of fibrin. At various points in the oedematous tissue of the tumor were small round nodular masses which projected above the cut surface. The fluid contained in the cysts was slightly alkaline, gave, on boiling, an abundant precipitate of albumen and had a specific gravity of 1017. Microscopic examination of the tumor showed that it was a typical fibro-cystic tumor. The small hardened nodules showed a myomatous structure very little altered. In other portions there was very extensive hyaline and mucoid degeneration. The tumor was covered by peritoneum, which could be stripped off.

Very truly,

W. T. COUNCILMAN.

When undertaking the operation, I was in doubt as to the exact character of the tumor, whether it was a fibro-cystic tumor of the uterus, or a compound multilocular tumor of the ovary. It was so large, and growing so rapidly, and the sufferings of the woman so great, that she demanded relief, and desired to undergo any operation which would give her a reasonable chance for life, and hence, I made every preparation, either for an ovariectomy or a hysterectomy.

In the *Lyon Médical* and *Journal de Médecine* for March 27th, Aubert states that headache and coryza resulting from full doses of iodide of potassium can be prevented by using belladonna. In one instance, in which five grammes of the iodide were administered daily, six grammes of extract of belladonna were also given. A few days later, the belladonna was discontinued, and iodism did not return.

The *Medical Record* suggests that the profession should erect a suitable monument to the memory of the late Professor Austin Flint, as well as to Marion Sims and Benj. Rush. Why not also include Gross, George B. Wood, Peaslee and a host of other distinguished men who have made American medicine famous?

## A CASE OF ACUTE MANIA. RECOVERY TAKING PLACE IN FIFTY DAYS.

BY A. L. HODGDON, M.D., FARMWELL, VA.

I was called sometime ago to see W. D., aged about 42 years, of neurotic family, who after sitting up for several nights with a sick child and worrying considerably over the condition of the same, suddenly manifested symptoms of acute mental exaltation. He was very violent, tried to knock his male friends (who were attending him) over and made attempts to stamp his feet through the floor etc. His shouting was heard by me before I entered the house, and I found his face suffused with blood, his limbs in almost constant motion, and his pulse 140 beats to the minute. He had been constipated for several days, (it is quite probable in his anxiety for the welfare of his child he did not even take the time in which to evacuate his bowels) and tympanites were present. His head had been blistered, and another blister was applied sometime later on during his illness, and he was taking the bromides. I ordered three or four compound cathartic pills and oleum ricini  $\mathfrak{zj}$  to be given at short intervals until bowels should be moved. Prescribed the following as well:

R. Extr. Digital. fluid. 3 ij

S. Three drops every three hours.

Careful directions were given in regard to alimentation. I tried to impress the family with the importance of regular nourishment, as the almost constant muscular efforts of the patient, with the continuous brain excitation, were liable ere long to completely exhaust the invalid. In about twenty-four hours his pulse had lowered to eighty, and within three or four days his bowels had commenced to act quite normally. It seemed almost impossible for him to secure any sleep whatever, and in the neighborhood of the third day, after I had first seen him, the brain storm through which he was passing seemed so great that it scarcely appeared as if he would be able to survive it. At this juncture the hot bath was



brought into requisition, but it was only after a great struggle that he would allow his hips to be immersed in it, it taking very nearly half a dozen men to keep him seated in the tub, as he had an idea we were trying to blow him up. He passed off some flatus while in the bath of a very offensive odor. About forty minutes elapsed from the time we attempted to put him in the bath to the time we took him out. Although, owing to his struggles, he did not remain in nearly that length of time—the temperature of the water being as high as he could bear it without being hot enough to burn him—the results accruing from the use of the bath were excellent in their secondary effect upon the brain, as it tended to dilate the blood vessels of the body, in that way creating a comparative anæmia of that organ, and bringing about a state akin to normal sleep. He almost went to sleep in the tub, and after being placed upon the bed fell into a doze, which, although a great thing for him, unfortunately lasted a very short time, only a few minutes. After he awoke he again passed into a condition of almost constant muscular activity. At one time appearing to play a fiddle and beating time to the same, at other times shouting, pleading or singing. I ordered an organette brought in the room, (the only kind of musical instrument that could be conveniently obtained right then and there) and told them to play on it at intervals during the day. It might be mentioned here that it diverted his attention and he appeared to enjoy the melodies. The almost constant muscular efforts of the patient (being regarded as a physiological protest against the pathological condition of the brain, and a war as it were between the two great factors of nature i. e., organization and decomposition) were made to seek other channels, in the way of giving him as much exercise in the open air as possible, principally by long walks. At this time he was taking the following.

R. Potass. Bromid.  $\bar{z}$ ij.  
Ext. Hyoseyam. fluid.  $\bar{z}$ ss.  
Aquæ  $\bar{z}$ xvj.

Fiat solutio et sig. Two tablespoonfuls ever three hours.

The muscular efforts were intense, and the bromide seemed to have hardly any effect upon him. I then ordered *Hemp* and pushed the administration of same (watching its effects very carefully) in the following form:

R\*. Ext. Cannabis Indic. 3i.

Alcohol  $\bar{z}$ ij.

Solve. S. Fifteen drops every four hrs.

About midnight, a short time after, I was called to see him as it was supposed by his attendants the he was worse than he had been, one of them considering him moribund. I found that his condition had become changed from one of mental exaltation to that of depression coupled with extreme obstancy, that depression which follows the severe cases of acute mania and may be looked upon as one of the stages of the disease on its road to recovery. He could not be induced to speak, simply making the most frightful grimaces. I ordered the head-bath, and as they were preparing to give it he spoke, as well as during the time he was taking it. He refused his nourishment, and it seemed as if recourse would have to be had to the stomach pump and mouth-opener in order to feed him. I remarked in his presence one night that if he did not take his nourishment by the next day we would have to use the stomach pump and force the food down him. This observation had the desired effect, as the next morning I found that he had taken some food. I now placed him steadily upon the following:

R. Potass. Iodid.  $\bar{z}$ ij.

Aquæ  $\bar{z}$ xv.

Fiat solutio et sig. Teaspoonful every eight hours, day and night.

R. Syrup Rhei Aromat.  $\bar{z}$ ij.

S. Teaspoonful every eight hours.

R. Potass. Bromid.  $\bar{z}$ ij.

Extr. Hyoseyam. fluid.  $\bar{z}$ ss.

Aquæ  $\bar{z}$ xvj.

Fiat solutio et sig. Two tablespoonfuls at bedtime.

R. Tinct. Ferri Chlorid.

Tinct. Nucis Vomiceæ  $\bar{a}\bar{a}$   $\bar{z}$ ss.

Acid. Hydrochloric. 3i.

\*The tincture was made from the English extract.

M. Et sig. Twenty drops three times a day in a glass three-fourths full of water; take after meals and through a straw.

He was also placed on Parke, Davis & Co's. oviform sugar coated pills of phosphorus, each containing  $\frac{1}{3}$  of a grain, one of which was ordered to be given every eight hours. The dose of the preparation of cannabis indica before named was now reduced to eight drops every eight hours. From this time on his improvement was continuous, (with the exception of several slight relapses) and it was not long ere his intellect became quite clear. During the whole course of the treatment *no chloral was used*. I am greatly impressed with the value of hemp in acute mania in quieting the motor disturbances, and its influence toward controlling the morbid brain reaction upon which I believe these depend. *i. e.*, if the drug be pushed and the effects of the same carefully watched. Professor Clouston in his work upon mental diseases, in speaking of a case where suppuration followed (in acute mania) upon the patient crushing through a tooth while a padded mouth opener was being used, and which was followed by a steady improvement and ultimately a perfect recovery, says: "There is one example of very many cases I have met with where a local inflammation, a fever, an internal disease, a carbuncle, a crop of boils, or septic blood-poisoning have cured insanity. We try to do the same thing sometimes in cases that are strong in body by severe blistering, but seldom succeed in producing the same marked and immediate effects. I believe that some day we shall hit on a mode of producing a local inflammation or manageable septic blood-poisoning, by which we shall cut short and cure attacks of acute mania." In the case of W. D., vaccination was resorted to by me with purely negative results; he had been vaccinated many years before and was probably protected thereby. A seton was established in the back of one arm, and I think it did good. He is now living with his family and I believe is inclined to be somewhat of a

philosopher, and has a strong tendency to look on the bright side of life, realizes what a severe attack he has passed through and is very happy over his recovery.

### Society Reports.

#### BALTIMORE GYNÆCOLOGICAL AND OBSETRICAL SOCIETY.

STATED MEETING HELD APRIL 11, 1886.

The President, GEORGE W. MILTENBERGER, M.D., in the chair. WM. E. MOSELEY, M.D., Secretary.

*Dr. Robert T. Wilson* read a paper on

HYSTERECTOMY FOR REMOVAL OF A FIBRO-CYSTIC TUMOR.\*

#### DISCUSSION.

*Dr. Thomas Opie* said he would like to ask Dr. Wilson whether he had ever had signs of poisoning or local irritation from the use of so strong a solution of bi-chloride of mercury as 1-2000. Judging from his experience with corrosive sublimate in obstetrical practice, one part in two thousand was much too strong. In one of his cases it had caused a severe metritis. He called attention to statements recently published that biniodide had proved to be quite as effective as the bi-chloride and can be safely used as a germicide, the strength of 1-4000.

*Dr. W. E. Moseley*, in regard to washing out the abdominal cavity with so strong a solution as that advocated by Dr. Wilson, would merely repeat the remarks he had made at a previous meeting. He considered that in placing such a solution in contact with so extensive an absorbing surface as that presented by the peritoneum and abdominal contents, there was great danger of general poisoning and also of local irritation. He believed that all the requirements would be met by the free use of freshly boiled water used

\*See page 64.



directly from the vessels in which it was boiled.

*Dr. W. P. Chunn* asked how soon the fluid removed from the larger or main tumor coagulated and what its appearance was.

*Dr. R. T. Wilson* answered that, as he had stated in his paper, the fluid was straw-colored and coagulated within two hours.

*Dr. H. P. C. Wilson* stated that he had repeatedly used the bi-chloride solution in the manner and strength advocated in the paper read and had never seen any bad effects follow; *Dr. Thornton* and other English surgeons use the same solution freely.

*Dr. T. A. Ashby* remarked that *Dr. Hofmeier*, of Berlin, had reported in the *American Journal of Obstetrics*, as far back as May, 1884, several cases of poisoning from the use of weak solutions of corrosive sublimate in the puerperium. *Bodlehner* has observed that sublimate solutions of 1-4000 for vaginal injections will produce some irritability, and in view of this fact, he thought solutions of 1-10,000 were sufficiently active for vaginal injections. What is true in this respect of vaginal injections is applicable to the use of the bi-chloride solution in abdominal surgery. The peritoneal membrane is a far better absorbent surface than the vaginal or uterine mucosa. When it is considered that the strength of the sublimate solution of 1-2000 is equal to three and a half grains of the bi-chloride of mercury to the pint of water and that frequently the abdominal cavity is irrigated with from one quart to one gallon of this antiseptic wash, an idea may be had of the danger of absorption from the ten, fifteen or twenty grains of bi-chloride in this manner used. In abdominal surgery the strength of the bi-chloride solution should be feeble. *Dr. Ashby* thought a solution of 1-10,000 amply sufficient when employed in this manner, and that the stronger solutions were dangerous in proportion to their strength.

*Dr. A. F. Erich* thoroughly agreed with the view expressed that for douching the abdominal cavity freshly boiled water would meet all the requirements. If

there were any suspicious points they could be touched with a sponge wet in the bi-chloride solution. He had nearly lost a patient from carbolic acid poisoning and it had put him on his guard against the too free use of corrosive sublimate. He thought a great deal depended upon the condition of the peritoneum and that we ought always to be on our guard lest free absorption and poisoning should take place.

*Dr. T. A. Ashby* read a paper on

#### THE INFLUENCE OF PREGNANCY AND PARTURITION UPON ORGANIC CARDIAC DISEASE.\*

##### DISCUSSION.

*Dr. A. F. Erich* said that some six or seven years ago he was called in consultation to see a woman who was some four months pregnant and had some form of organic heart disease, the exact character of which he did not remember. The question to be decided was whether or not abortion should be induced. He advised allowing the woman to go on to full term and was afterwards called upon to attend her in her labor. He used morphia in quantities just sufficient to control the nervous system and when labor pains fairly set in used chloroform systematically and delivered very slowly by forceps, simply helping each contraction. The result was perfectly natural recovery. He thought that if *Dr. Ashby* had been able to be with his patient from the first, the result would have been very different, as he believed that the death was due rather to the nervous disturbance than to the hæmorrhage.

*Dr. W. T. Howard* said that he had listened with great pleasure to the reading of *Dr. Ashby's* lucid and interesting paper. He thought, however, that the statistics collected by *Dr. Macdonald*, giving a mortality of 17 out of 28 cases, or 60 per cent. from the deleterious effects of pregnancy and parturition on chronic organic disease of the heart, much higher than is usually seen in pri-

\*See page 61.

vate practice. He had attended many ladies in private practice during their accouchment who were suffering from severe cardiac lesions, and he did not remember a single death. Dr. Howard felt well assured that he would be sustained in this statement by our President, whose experience in, obstetrics, as we all know is immense. He would ask if such had not been the result of Dr. Miltenberger's experience—if such cases did not usually pass safely through the pangs and perils of labor, with due care and attention?

Dr. Howard said that the mortality in the cases under discussion would doubtless vary with the nature and extent of cardiac lesions. It is now well known that there is a physiological hypertrophy of the heart during pregnancy, to sustain the burden imposed by the demands of a quickened circulation and the complicated exigencies of the constantly growing uterus; and some cardiac lesions are much more dangerous than others. Thus mitral stenosis is especially apt to occur during the period when child-bearing is most active, rarely occurring after fifty years of age, and is at least twice as frequent in females as in males. And as stenosis of the mitral orifice is generally accompanied by mitral insufficiency, this complicated condition is particularly dangerous during pregnancy and parturition. Aortic stenosis, also, is generally associated with aortic insufficiency, more or less and is always accompanied by hypertrophy of the left ventricle. So long as the hypertrophy is sufficient to compensate for the regurgitation, grave symptoms seldom supervene. Dr. Howard well remembered attending a lady some fifteen years ago, aged 25 years, who had well-marked aortic stenosis, and, also, slight insufficiency. The labor was severe and protracted and finally the vital forces began to flag and orthopnoea was distressing. But by propping up the shoulders and delivering with the forceps all went well. This lady is now living and enjoys a fair proportion of health. When the mitral regurgitation is the predominant lesion, the patient may long remain free

from distressing symptoms. The left auricle first feels the strain, from pressure of the two blood currents during diastole, one from the left ventricle and the other from the lungs, and begins to dilate and hypertrophy. This leads to compensatory hypertrophy of the right ventricle, which overcomes pulmonary hyperæmia and its inevitable train of dreadful sufferings. And as long as hypertrophy of the right ventricle is sufficient to counter-balance the effects of regurgitation, serious symptoms do not result. Dr. Howard remembered the case of an eminent literary gentleman from Virginia, who consulted him in April, 1861 and who had a loud mitral regurgitant murmur. He is now living and ably editing a newspaper, and occasionally writing excellent poetry.

Dr. Howard thought it very probable that had Dr. Ashby been present when delivery occurred in his case and rendered proper assistance with the forceps, as he certainly would have done, and promptly removed the placenta his patient's life would have been saved. It is to the last degree important in all cases of labor occurring in women suffering from organic affections of the heart, that the accoucheur be present from the commencement to the close, in order to render prompt assistance in any exigency that may occur. But is not always easy to discriminate between organic and inorganic murmurs, so as to determine whether a given case has a functional disorder or an organic lesion of the heart, a practical point of great moment, to which Dr. Ashby did not allude in his well-written paper. Some years back, Dr. Howard had seen a gentleman in consultation with his good friend Dr. J. W. Houck, of this city. Six physicians, some of them excellent auscultators, saw the patient; three thought the loud systolic murmur indicated grave organic, and three were equally confident that it was inorganic, and induced by extreme anæmia. The latter opinion proved to be correct, as the murmur completely subsided under appropriate treatment.

In that remarkable book, which so charmed the Medical Mind about a third



of a century ago, its eminent author\* directed special attention to the difficulties encountered in *Anæmia Gravidarum* in distinguishing between true organic lesions of the heart, and what he terms "*seeming diseases of the heart.*" He draws in his own striking and inimitable manner, vivid pictures of the latter, characterized by palpitation, great increase in the area of cardiac pulsation, dyspnœa, orthopnœa, etc. Even now the chapters he devotes to the subject will well repay perusal. Dr. Howard attended a bright mulatto woman in the Spring of 1862, during the last two months of her pregnancy, but was unable to be present at her accouchment. She was extremely anæmic and anasarca, and suffered dreadfully from slight exertion. Anæmic soft and blowing murmurs were well marked over the heart and in the carotids, accompanied by a venous hum. But Dr. Meig's statement that the most extravagant deviations in the heart's action in such cases are greatly lessened or wholly disappear, so long as the woman remains at rest in the recumbent position, was beautifully exemplified. This is a diagnostic point of great importance; for as Dr. Meigs forcibly states, though the derangements of the heart's action are frightfully aggravated, when organic lesions exist, by exertion, they do not wholly disappear in a state of profound rest.

Dr. George W. Miltenberger said that in his experience cases of confinement complicated by heart disease almost always result favorably.

Dr. Thomas Opie considered that, although the bellows murmur heard during pregnancy is generally due to hydræmia, yet he saw no reason why pressure of the enlarged uterus against the abdominal aorta should not cause a regurgitant murmur under certain circumstances at the aortic valves. He felt certain he had seen reference to the same idea in print recently. So long as there was the physiological slowing of the pulse following labor he felt safe, always considering an increase in the heart beat shortly after labor as a warning of ap-

proaching hæmorrhage or later on of blood poisoning.

Dr. W. T. Howard thought it very improbable that the pressure of the uterus or any intra-abdominal tumor against the aorta would cause *any* heart murmur. He would ascribe such a murmur either to anæmia or previous valvular disease.

Dr. T. A. Ashby closed the discussion by saying that he fully coincided with Dr. Erich's views in regard to the inadvisability of inducing premature labor or abortion in cases of pregnancy with advanced cardiac disease. There are two objections to the method; first, the effort to deliver in premature labor is, if anything, more injurious to these cases and more liable to bring about disturbances of the circulation than labor at full term. In the second place premature labor almost of necessity involves the destruction of the child and thereby jeopardizes two lives, whereas in labor at full term the life of the child is not necessarily complicated by reason of the existence of cardiac disease in the mother. In the case reported by Dr. Ashby a vigorous, healthy child was born, which to some extent compensated society for the loss of its parent. Dr. Ashby recognized the importance of the points stated by Dr. Howard. In the case reported the diagnosis of organic cardiac disease was carefully made and functional heart murmurs were discounted. The patient had no œdema, no anasarca, and her anæmia was not sufficient in itself to have accounted for the mitral regurgitation and aortic obstructive murmur. The patient had a previous history of rheumatic endocarditis which unmistakably accounted for organic changes. He was clearly of the opinion that the hæmorrhage following the delivery of the child was sufficient to account for the disturbance of the heart's action, and he believed that this loss of blood could have been avoided had he been present at the birth of the child. On the other hand the hæmorrhage was not in itself sufficient to have destroyed the life of this patient. Had the equilibrium of the circulation been provided for by compensatory arrange-

\*Chas. D. Meigs, M.D. *Woman, Her Diseases and Remedies.*

ments and the duty of maintaining the circulation been performed by the heart its action would not have ceased. In referring to the prognosis of pregnancy in cardiac disease Dr. Ashby agreed with the views expressed by the President and by Dr. Howard. He thought Dr. Macdonald had taken a too unfavorable view of the prognosis—Macdonald had reported a mortality of 60 per cent. which was certainly very high. In a recent discussion before the Obstetrical Society of London (*British Medical Journal*, April 24th, 1886, page 781,) this subject had been discussed and this view of Macdonald's prognosis had been expressed by several speakers. The practical point to be considered in connection with cases of pregnancy associated with organic cardiac disease has reference to the treatment of the patient during labor. Knowing that cardiac diseases exercise an unfavorable influence upon the prognosis of labor the obstetrician should give close attention to these patients and should see that the condition of the heart was not influenced by excitement or other causes liable to induce shock or suspended action.

#### A CASE OF INTRA-PERITONEAL OR POST-PERITONEAL ABSCESS.

*Dr. W. E. Moseley* reported the following:

Mrs. F., aged 25, a light mulatto woman, between two and three years ago, first noticed a painful swelling occupying the right fossa and which confined her to her bed for several days. The tumor developed rapidly, was accompanied by pain was sensitive to touch and was coincident with a decidedly constipated condition of the bowels. The patient attributed the trouble to straining or bruising from carrying heavy market baskets. A blister was applied and in a few days the swelling disappeared and no more attention was paid to it until last November. At that time she was in the country nursing her sister, whom she had to lift and who was a very heavy woman, and while thus employed the swelling reappeared. On her return home she was seen by

various physicians who gave her internal medication, but without producing any diminution in the size of the tumor.

I first saw her February 26th, and at that time obtained the following history in addition to the facts already related. Menstruation had been regular and without marked pain, until about seven years ago, when it ceased and has not reappeared, but at each period since there has been some pelvic discomfort. She has never known herself to be pregnant. General health was always good until the first appearance of the tumor, nearly three years ago, since which time she has been failing. Bowels rather constipated, but appetite very good. Examination of the abdomen showed a well defined oval tumor occupying the right iliac fossa, about six inches in its longest diameter, parallel to the crest of the ilium, and extending about three and a half inches toward the median line. It was somewhat sensitive on deep pressure and had an elastic feel, as though there might be fluid confined beneath thick but tense walls. The swelling could not be felt *per vaginam*. There was a sharp cervicocorporeal ante flexion of the uterus, and on the left lateral wall of that organ was a small fibroid tumor about the size of a hickorynut, with its attachment nearly in a line with the internal os. There was no connection between the abdominal tumor and the uterus. The bowels were constipated but kept open by enemata and laxatives. The pulse averaged about 84 and temperature 99. +°. The patient was confined to her bed nearly all the time from weakness, abdominal discomfort and inability to walk.

For about two months I tried the effects of counter-irritation with iodine and blisters and the persistent use of heat together with copious hot vaginal douches, and general tonic treatment, but the tumor increased slightly in size, and on April 20th, assisted by Dr. C. H. Riley, a thorough examination was made under ether which confirmed the results of the previous examination. An aseptic hypodermic needle was intro-



duced about two inches anterior to and on a line with the anterior superior spinous process of the right ilium and clear laudable pus withdrawn. Both Dr. Riley and myself thought that a free opening with drainage would give the patient the best chances of recovery in the shortest possible time, so, under the free use of 1-2000 solution of bichloride of mercury, an incision two inches long was made two inches from and parallel to the crest of the ilium and extending down to the peritoneum. The peritoneum and sack of the abscess were stitched together by two rows of interrupted sutures, three on each side, after a greater part of the pus had been removed by the aspirator. An incision was made between the rows of sutures, a rubber drainage tube introduced and made fast to the abdominal wall and the skin and muscle brought together by two silk sutures. About five ounces of pus were obtained. The abscess was washed out morning and night for several days, with 1-8000 bichloride sol. iodoform sprinkled around the incision and the whole covered with tarred jute. The discharge was very slight from the first. On the second day the pulse reach 102 and temperature 101.9°, but after that the pulse ranged between 80 and 90 and the temperature between 98 and 99° F. in the axilla. The drainage tube was removed on the fifth or sixth day and the cavity washed once daily. The patient sat up on the fourteenth day and since then the cavity has been washed out every second day. The abdominal incision healed by first intention. There now remains a sinus extending about two inches inward and slightly upward, the induration is rapidly disappearing and there is no more pus obtained than can be accounted for by the walls of the sinus.

The questions of special interest to me at the time of the operation were, what tissue and from what cause did the collection of pus originate, and what was the prognosis? My opinion was that the abscess was intraperitoneal and due to an old perityphlitis or in the cellular tissue behind the reflection of the peritoneum, with a decided leaning

toward the former. The condition of the patient at the present time, I think, demonstrates pretty clearly that the abscess was not due to necrosed bone.

Dr. W. T. Howard had seen a somewhat similar case in a child 4 or 5 years of age. The abscess was opened freely and about a pint of pus evacuated. The child recovered.

Dr A. F. Erich would consider the cause as probably perityphlitis.

Dr. Geo. W. Milltenberger thought such abscesses frequently occurred without our being able to trace them to any specific cause. He thought the one reported by Dr. Moseley was probably situated in the cellular tissue behind the reflection of the peritoneum.

(To be continued.)

HYSTERIA IN SOLDIERS.—Dr. A. T. Ozeretskovski describes in the Russian *Medical Review* a whole series of cases of hysteria occurring in soldiers, presenting nearly all the phenomena usually associated with this affection as it occurs in females—dumbness, deafness, deaf-mutism, various disturbances of vision and of general condition, spasms and paralysis, troubles connected with micturition, joint trouble, elevations of temperature, &c. The subsequent history of the cases in most instances left no doubt of the correctness of the diagnosis. Predisposition and heredity played a large part in the etiology, and in some instances there was injury or shock. Half the patients were recruits, which tends to show that the sudden change from domestic life and work to the arduous conditions of military service is not without effect on the nervous condition of the Russian soldier. The treatment of the hysterio-epileptic cases was always unsuccessful, neither water, electricity, nor narcotics appearing to exert any influence over the frequency or severity of the attacks. The cure of the paralytic forms of the disease was successfully accomplished by means of exercise, gymnastics, &c.—*Lancet*, April 10th, 1866.

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BALTIMORE, MAY 22, 1886.

**Editorial.**

DR. LATHAM ON THE TREATMENT OF GOUT AND RHEUMATISM.—In the Croonian Lectures, recently delivered at the Royal College of Physicians, of London, Dr. P. W. Latham, Downing Professor of Medicine at Cambridge, has presented in a very thorough and exhaustive manner the most recent views upon the Pathology of Rheumatism, Gout and Diabetes. These views are quite worthy of most careful reading. After discussing the chemistry of these pathological affections, Dr. Latham arrives at the conclusion that uric acid and lactic acid are after all the essential causes of these affections. The manner in which these two substances are manufactured in the economy is very ingeniously demonstrated by chemical formulæ which, to say the least, are perhaps beyond the grasp of the average reader. We shall not attempt to state the various steps which explain the origin of uric acid and lactic acid in the human body and how their presence may cause the symptoms of rheumatism and gout, but will call attention to the more practical part of these lectures expressed in rules which are designed to govern the treatment of these diseases. Dr. Latham states that in gout uncomplicated with contracted kidney or albuminuria salicylic acid is often of service, but he claims that it is in acute rheumatism that this drug shows its special power, acting truly, when properly administered, as a

distinct specific. But in order to ensure success in the administration of this drug Dr. Latham claims that certain conditions must be observed. These conditions are stated in the following rules:

1. "The true salicylic acid obtained from the vegetable kingdom must alone be employed. If you have to give large doses, avoid giving the artificial product obtained from carbolic acid, however much it may have been dialysed and purified. An impure acid will very quickly produce symptoms closely resembling delirium tremens.
2. Give the acid without any alkali or base. A very good form is to mix 100 grains with 15 grains acacia powder and a little mucilage. Allow the mass to stand and harden, and then divide into thirty pills.
3. Place the patient fully under the influence of the drug—that is, let him have sufficient to produce cerebral disturbance—*i. e.*, buzzing in the ears or headache, or slight deafness; with the development of these symptoms the temperature and the pain in the joints will begin to decline. To an adult I generally administer three doses of 20 grains (six pills) at intervals of an hour, and if the head remains unaffected, a fourth dose at the end of another hour; and the repeat the 20 grains every four hours until the physiological effect of the remedy shows itself. In the majority of cases from 80 to 100 grains are enough. In severe cases 140 to 150 grains may be required. Afterwards about 80 grains a day are sufficient, and as the temperature declines smaller quantities will develop their physiological effects, 60 or even 50 grains being then sufficient to produce cerebral disturbance. It would appear that as long as the rheumatic poison is circulating in the system, the physiological effect—that is, the effect it produces in the healthy organism—does not show itself; acting as an antidote, the greater the amount of poison the larger must be the dose of the remedy; but as soon as the formation of the *materies morbi* is stopped, then the excess of the remedy acts as it would in the healthy organism and its peculiar physiological effects are developed. It is



a very striking illustration of the difference between the therapeutic effect of a remedy and its physiological action. 4. Give the patient from 40 to 80 grains daily for ten days after all pain and pyrexia have passed away. 5. Let the patient's diet consist entirely of milk and farinaceous food for at least a week after the evening temperature has been normal. On the other hand, if the patient has meat and soup, you may look forward with fair probability to a relapse. 6. Take care to maintain a daily and complete action of the bowels. Calomel is the best purgative, from 2 to 5 grains at night, followed in the morning, if necessary, with a saline draught. This is the most important adjuvant to the action of salicylic acid, and I will presently explain to you why this is the case. 7. Let the patient be enveloped in a light blanket, and with more bed-clothes than are sufficient to keep him from feeling cold. The object of the treatment now is to cool the patient—not, as in former times, to sweat the poison out of him; and the cooler he is kept the sooner will the temperature be lowered. In fever increased heat increases the metabolism just as in a cold-blooded animal."

These are the rules upon which Dr. Latham acts. In this connection he says:

"I have given the true salicylic acid where there have been both aortic and mitral mischief; and I have also given it in rheumatism complicated with pericarditis, and as yet I have seen no bad result from it. Of course in cases of pericarditis, accompanied with delirium, the use of the remedy requires caution; you cannot tell when the system is saturated with the remedy, and you must therefore trust to smaller doses and other means for controlling the disease. Further, if pericarditis or endocarditis, or pluri-sy have been developed, the remedy is powerless over the mischief which is done; it will neutralise the poison producing the mischief so as to stop its extension, but the inflammatory exudations will undergo their usual changes unabbreviated in their course. We see the same thing in tonsillitis.

Given early enough, salicylic acid will stop the mischief, but if exudation of lymph has taken place salicylic acid is powerless to cause its absorption."

Referring to the necessity of keeping up daily and sufficient action of the bowels Dr. Latham says that by the judicious use of cholagogue purgatives the bile is eliminated from the intestines and a quantity of glycocine is thus removed from the system which if re-absorbed would lead to consequent formation of uric acid: "Calomel is unquestionably of service here. Doubts may exist as to whether it promotes the flow of bile from the liver or not, but when the bile gets into the intestine calomel will cause its evacuation."

Again he says: "In the earlier attacks of gout, too, I have often seen marked relief follow the administration of calomel and a saline cathartic. Where there is high arterial tension, as in the gouty paroxysm, this may be distinctly lowered by these remedies. They check the further formation of uric acid which is stimulating the vasomotor centre and causing the increased arterial tension, by eliminating the bile from the intestines. In some persons calomel has a depressing effect, and when the kidneys are unsound is injurious in its action. Where calomel is inadmissible, a gentle laxative such as rhubarb is often of service. When the object is simply to unload the bowels in a debilitated subject, it is the best purgative. It is said to act chiefly by increasing the peristaltic action of the bowels throughout their entire extent, but especially that of the duodenum. According to Rutherford, it is a cholagogue. Sir Henry Hallford recommended it as a prophylactic remedy against gout: a few grains of rhubarb with double the quantity of magnesia every day; or some light bitter infusion with tincture of rhubarb and about fifteen grains of bicarbonate of potash. The saline cathartics probably act only by causing serous evacuations, and in that way carry off from the blood some of the poison contained in it. They may also act beneficially, perhaps, by relieving a congested liver."

"The diet is another important point to be attended to in the treatment both of gout and rheumatism. It should be simple and nutritious; jellies and food containing gelatine should be avoided, as this substance furnishes glycocine. Animal food will not itself produce uric acid in a healthy system, as is shown by its absence in the urine of the carnivora; but from all kinds of meat a certain amount of glycocine will be produced, and even if all the rest of nitrogenous portion, after being absorbed in the system were converted into urea, this would necessitate an increased elimination of urea, and consequently a greater tax on the powers of the kidneys. If these powers are weakened, there will be, with an increased call upon the organs, less power to act, and not only the urea, but still more, the uric acid, would accumulate in the blood. The striking benefit and increased urinary secretion which result in some forms of albuminuria from a skim-milk diet—that is, the simplest of all diets—very well illustrate what I mean here. The presence of urea in the blood may, by its action on the nerve-centres, determine an increased blood-supply to the kidneys, and so, in a health state of things, an increased flow of blood to the part, producing a congested condition of the organ, would not expedite, it would rather hinder, the work of the secretory portion. The simpler the diet then, the less tax there will be upon the kidneys, and the better they will do their work. Let the diet be chiefly farinaceous, with just sufficient nitrogenous food to satisfy the wants of the system—and in acute attacks let that be in the form of milk, diluted even if necessary."

EXPERIENCES IN REGARD TO THE HEALING OF WOUNDS WHEN COMPLETELY SUTURED WITHOUT DRAINAGE.—It may be remembered that attempts have been made within the past few years to secure the healing of even very large wounds without drainage. This method either had its revival or originated at the surgical clinic of Kiel, in the hands of Prof. Esmarch and Dr. Neuber. In

order to accomplish the complete healing of a large amputation or resection wound without drainage, it is necessary to have an intimate acquaintance with both the theory and practice of antiseptic treatment, but more than this is required, viz., the accurate apposition of the wound surfaces, and this is effected by the use of "buried sutures," or the suturing of the different anatomical elements of the flaps separately. Thus the peritoneum is first sutured over the end of the bone; then the muscles are sutured and finally the skin. The suture material is either a septic silk or catgut. By means of this separate suturing the whole surface of the flaps is brought evenly together, and by the pressure exerted upon all portions of the stump, secretions are nearly or quite prevented. The subject was prominently brought to the notice of English speaking surgeons sometime last year by Mr. C. B. Keetley, of London, in a suggestive article published in the *British Medical Journal*, Vol. 1, 1885, in which he gives the results of his experience in the use of buried sutures without drainage in such operations, as amputations of the thigh, osteotomies, wiring the patella, excisions of hip, resections of tendons, and other serious procedures, seventeen in all. He says: "In all these seventeen cases, except two, the buried sutures have done all which sanguine hopes could expect of them. But in stating this, I must confess that I have not always dared to dispense with drainage tubes." At a discussion of a paper by Prof. Küster at the meeting of the Society of German Surgeons, held in Berlin, in 1884, Prof. Esmarch stated that by the use of buried sutures, drainage could be dispensed with, even in such extensive wound cavities as are left after excisions of the hip joint. Mr. Keetley, in such large operations, used the buried sutures, but also provided for drainage, which seems to be at least a reasonable precaution. Since the beginning of 1884 efforts have been made to secure healing of wounds by the complete suturing of the flaps without drainage, at Prof. Albert's clinic, in Vienna; and Dr. Karl Maydl gives the



result of the treatment in a recent article (see *Centralblatt für Chirurgie.*, 1886, April 10, p. 264). Within a year thirty-two amputations have been performed with thirty-one recoveries, and one death from secondary hæmorrhage from the femoral artery. The method of amputation employed was the circular for the leg and forearm, double flaps for the thigh and arm. In thigh amputations the flaps were held in contact by means of deep sutures, whilst the skin is completely united with interrupted sutures. The stump is covered with a compressing dressing and is immobilized with a stock bandage. The thigh amputations all united by primary union, with the exception of one case where there was a circumscribed suppuration on account of fistula from a caseous inguinal gland. The amputations of the leg did not do as satisfactorily as the above, for only seven out of eleven healed properly. Once gangrene occurred, with fever, twice gangrene without fever, and once suppuration. In the cases which did not pursue a satisfactory course, the cause of the disturbance was not the failure to employ drainage, but the fact that too strong compression was made upon the stump. In large irregular cavities following resections, etc., it was found best not to close the wound tightly, but to employ a drainage tube in order that the secretions might escape. On the whole the method of suturing the wounds tightly, without drainage, gave very good results, but we do not see what material advantage was derived from so doing. The introduction of a tube disturbs a wound so little and adds so much to the safety of the patient, that it seems to us it should always be used in large wounds, especially if the cavities are ragged and irregular. Buried sutures do not appear to have been used at Prof. Albert's clinic, but deep through and through sutures. We have made a few trials with the use of buried sutures, but did not get very good results, owing perhaps to defective antisepsis; at any rate considerable suppuration followed their employment. To summarize: The results of attempts to heal large wounds

without drainage do not appear to be sufficiently favorable to ensure the general adoption of the method, though in the hands of a few surgeons successful results have been attained; especially where buried sutures have been employed for suturing the different portions of the wound separately, so that the whole surface of the wound is in accurate apposition.

### Miscellany.

VALUABLE SUGGESTIONS IN THE USE OF LACTATED FOOD.—Dr. J. Milner Fothergill having been requested to give his opinion, as a food expert, upon "Lactated Food," writes as follows to the proprietors Messrs. Wells & Richardson Co.: "You state that it contains 'the purified gluten of wheat and oats with barley diastase and malt extract combined with specially prepared milk sugar;' in other words, that it is self-digestive as regards the conversion of insoluble starch into soluble dextrine and maltose. My experiments with it lead me to hold that this is correct.

The food then contains carbo-hydrates, some albuminoid matter and the various salts in grain, notably phosphate of lime.

Such a food can be added to milk and treated in the manner you describe in your leaflet. So prepared with milk it forms an admirable food for infants and dyspeptic persons who require very digestible aliments.

But it has a wider range of utility. The body-temperature is kept up by the combustion of grape sugar. Grape sugar is supplied from carbo-hydrates, either the insoluble starch, or the soluble sugar. Starch forms a great portion of our food and is converted into grape sugar within the body. Where the system is unequal to the digestion of starch, as in feeble digestion, or conditions of acute disease, then predigested starch must be furnished to the organism. Otherwise the system will perish of exhaustion, just as a fire dies out when its fuel is consumed.

Beef tea contains nothing which can form grape sugar, and in fact is a pleas-

ant stimulating beverage or food adjunct; but without food value practically (For what food value it has is so infinitesimal that it is not worth counting). But when it has added to it a food such as your Lactated Food it has a distinct measurable food value. Consequently such food should be given with beef tea, and the compound forms a valuable food.

When Lactated Food is placed in water hot enough to be sipped a rapid transformation of the starch remaining in it (by the diastase it contains) goes on; and a nutritive fluid is the result which requires but a minimum of the digestive act.

Such fluid can be flavored and drank as nutritive beverage, specially acceptable in febrile conditions. Flavored with lemon, ginger, cloves or other flavoring agents to give a variety—a matter far too much neglected in the treatment of the sick—it can be largely used. Or wine, either red wine as claret, or sherry or port, can be added to it when a little stimulant is required; and brandy when a stronger stimulant is indicated.

The resort to farinaceous matters, predigested, must become greater and greater as our knowledge of digestion and its derangements waxes larger. It is not merely in the case of the feeble infants that such predigested starch and milk sugar are indicated and useful; persons of feeble digestion require these soluble carbo-hydrates which they can assimilate.

But to my mind an equally great matter is the feeding of persons acutely sick, and especially where there is pyrexia, who now are allowed to perish of inanition on the mistaken conviction that beef tea is a sustaining food. It is in the sick room that soluble carbo-hydrates have a great future before them."

PROGRESS OF THE PRELIMINARY ORGANIZATION OF THE INTERNATIONAL MEDICAL CONGRESS.—At a recent meeting of the Executive Committee of the Ninth International Medical Congress, held in St. Louis, Mo., on May 3rd, the following changes in the organization of the Congress were announced: Dr. J. A.

Grant, of Ottawa, Canada, was elected Vice-President, vice, R. Palmer Howard, of Montreal, resigned. Dr. J. F. Harrison of the University of Virginia, was elected President of the Section of Gynecology; Dr. J. H. Callender, Professor of Physiology in the Nashville and Vanderbilt Universities, was elected President of the Section of Physiology; Dr. A. B. Palmer, of the University of Michigan was elected President of the Section of Pathology; and Dr. E. Williams, of Cincinnati, was elected President of the Section of Ophthalmology.

A Section on Laryngology was organized with Dr. W. H. Daly, of Pittsburgh, Pa., as President, and Dr. Wm. Porter, of St. Louis, Mo., Secretary.

Dr. H. O. Marey, of Boston, was at his request transferred from the Presidency of the Section on Collective Investigations etc., to the Vice-Presidency of the Section on Gynecology, and Dr. A. L. Gihon, U. S. N., was promoted to the vacancy made by Dr. Marey.

The Committee will soon issue a second circular giving the Preliminary Organization of the Congress.

DR. OLIVER WENDELL HOLMES' VISIT TO EUROPE.—Dr. Oliver Wendell Holmes left Boston for Europe during the present month, and will pass the summer on the other side of the Atlantic. It is just fifty years since he last visited Europe. The *British Medical Journal* (April 10th, 1886), referring to Dr. Holmes' visit, gives expression to the following sentiments, which will be highly appreciated by his many friends in this country:

"The promised visit of Dr. Oliver Wendell Holmes to this country within the next few weeks will doubtless give some opportunity to his many friends on this side of the Atlantic to testify their regard. Dr. Holmes represents some of the best traditions of the profession. Though the prime of his life was given to the arduous and apparently congenial duties of Professor of Anatomy in Harvard University, he has yet achieved for himself a position in literature which is, at the present moment, almost uni-



que. There is probably no living American, and few, if any, living Englishmen, who have been so widely read by the brain-workers, who are the marrow of the country. Dr. Holmes has made himself a medium of communication between the best thought within and the great thinking world without the profession of medicine. It is one of our greatest misfortunes, as a profession, that we have so comparatively few channels of intercommunication with the outside public; and, as medicine grows more complex and absorbing, so does the danger grow. Such men as Dr. Holmes bridge over the chasm in the most effectual way. Respected on both sides, they help to teach the lesson of mutual tolerance and respect."

LOCAL REMEDY FOR NEURALGIA.—A mixture of one part of iodoform to ten or fifteen of collodion, if spread repeatedly upon a neuralgic surface until it attains a thickness of one to two millimetres, is said to be quite effective in the treatment of certain neuralgias. If the first application does not speedily terminate the neuralgia, those who have used this mode of treatment direct that its application should be continued. It seems especially valuable in the relief of neuralgias of the trigeminus. It also seems of value to be applied along the spine, particularly at painful points in what is called spinal irritation. These observations are by no means new, and yet they seem worthy of further consideration.—*Neurological Review*.

MYRTOL.—Myrtol has only been, hitherto, studied as a curiosity. Dr. Linarix, in his doctoral thesis, *De l'Emploi du Myrtol*, gives a complete account of the properties of this substance. Myrtol is both an antiseptic and a disinfecting agent. By its presence, it prevents the decomposition of fermentative and putrescible organic substances; applied to the skin, it does not produce the slightest irritation, if the epithelium be intact. If there be a slight abrasion, a few drops will produce a very trifling burning sensation, which quickly goes

off. Myrtol stimulates the digestive faculties; all who use it find their appetite increased. In small doses, it acts as a sedative. It is eliminated by the lungs and kidneys, and has also a powerful balsamic action, but is more easily tolerated than most balsams. Its use is not followed by dyspepsia, nor by any of the other troubles attending the use of balsams in general. Dr. Linarix says that myrtol does not produce the same result at all periods of the affections of the respiratory system: in subacute and chronic catarrhal affections, it should be administered when fever has subsided; then the sputa become less abundant, also less purulent. Six capsules daily, each containing fifteen centigrammes of myrtol, form a moderate dose, which should be taken before meals.—*British Medical Journal*, April 10, 1886.

ANOTHER NEW COLLEGE.—The *Hæmæmænian Monthly* says: "A movement has been started in Baltimore, Md., toward the organization of a homœopathic college in that city, and we are informed that a charter has been already obtained and a faculty selected, and that the college will 'commence business' next autumn."

"Homœopathy does not flourish in Baltimore as in most American cities of its size. Notwithstanding the wealth of its citizens, it has no hospital, and but one public dispensary. It has considerably less than half as many homœopathic physicians, in proportion to population, as most of our other large cities; and, as we have already intimated, its annual addition to the number is almost contemptibly small.

There is probably no city of equal size in this country, in which a homœopathic college is less needed, or less likely to prove a real and valuable success. Looking at the subject from all sides, the new venture seems more likely to be productive of harm than of good, at least for a number of years. And it also appears as if the multiplication of low-rate homœopathic colleges in the United States is to go on indefinitely. Is the profession utterly helpless in this matter?"

## Medical Items.

The North Carolina Board of Health has begun the issue of a monthly "Bulletin."

A prominent publisher of regular medical works has said that he sold more books, proportionately to homœopaths than to regular physicians.—*Med. Record*.

The College of Physicians and Surgeons of New York, held its annual commencement exercises at Steinway Hall on Thursday, May 13th. An address to the graduating class was delivered by General Horace Porter.

A correspondent to *The Lancet* says he has used successfully, for the troublesome itching in jaundice, the hypodermic injection of one-tenth of a grain of pilocarpine. It caused some increase of the itching at first, but relief soon followed, and lasted from twenty four to thirty-six hours.

Mrs. Leland Sanford, wife of the millionaire Senator from California, has purchased a piece of land on Washington Avenue, Albany, adjoining the site of the old Lathrop mansion, and it is stated that on the whole property she will erect a handsome and well-appointed hospital for old men and women, as a memorial of her parents.—*Boston Medical and Surgical Journal*.

At the recent meeting of the American Climatological Association the following were elected officers for the ensuing year: President, Dr. F. Donaldson, of Baltimore; vice-presidents, Drs. H. Y. Bowditch, of Boston, and Roland G. Curtin, of Philadelphia; secretary and treasurer, Dr. J. B. Walker, of Philadelphia; additional member of council, Dr. F. C. Shattuck, of Boston.

It is officially reported to the "Gazette hebdomadaire de médecine et de chirurgie," that, during the year of 1885, 518 animals were ascertained to be affected with rabies, including 503 dogs, 13 cats, and 2 horses, and 527 were reported as suspected to be suffering with the disease, 64 bites by rabid animals were officially reported, and 19 persons died of rabies.—*N. Y. Med. Journal*.

The *Medical Record* states that a physician in New York City is said to have the following inscription on his bill-heads: "A patient's gratitude to his doctor is a part of his disease, and is most declared when the fever is highest, cools off during convalescence, and entirely disappears with the complete return of health. All bills due upon presentation. Office prescriptions and attendance strictly cash."

Dr. Brown-Séquard says that a "cold" usually results from the reflex influence of cold air upon the sensitive nerves of the nucha. He proposes to overcome the peculiar sensitiveness of these nerves by blowing with a pair of bellows upon the neck, using first

warm air, which is to be gradually cooled, until the patient can stand any sort of a draught (of air, not of liquid) without sneezing.—*Med. Record*.

At a recent meeting of the Academy of Sciences, Paris, M. Pasteur announced that he had treated the following number of people from the different countries for bites from mad dogs: France, 505; Algeria, 40; Russia, 75; England, 25. Italy, 24; Austro-Hungary, 13; Belgium, 10; North America, 9; Finland, 6; Germany, 5; Portugal, 5; Spain, 4; Greece, 3; Switzerland, 1; Brazil, 1. This makes a total of 726.—*Med. Record*.

Dr. R. B. Morison of this city, has gone to Europe to spend the summer. He goes first to Hamburg for one month to be with Professor Unna, who has now one of the largest public and private practices in dermatology in Germany. Dr. Morison also goes to Berlin for a month and later on to Prague, Vienna, and London. During his absence from Baltimore his assistant Dr. Newberry A. S. Keyser will attend to his practice and to his excellent clinic at the Polyclinic.

The St. Louis daily papers improved the occasion of the meeting of the American Medical Association for a good display of journalistic enterprise. Cuts of various gentlemen of greater or less prominence were published and the various types of manly beauty in the West were very liberally represented. The opportunities of the ball were also met with the true Jenkinsian fervor, and some seven or eight columns of the *Globe Democrat* chronicle what was worn by various "Mrs. Drs." and their daughters.—*Boston Med. and Surg. Jour.*

The Alumni Association of the College of Physicians and Surgeons held its annual meeting on the evening of May 11th. The alumni prize of \$500 was awarded to Dr. William Gilman Thompson, of New York, of the class of 1881, for an essay entitled "The Application of Instantaneous Photography to the Study of Physiology and Therapeutics." The donations made to the laboratory fund during the year were announced, including one of \$5,000 from Mr. Morris K. Jessup, and one of \$10,000 through Dr. W. H. Draper. We understand that the fund amounts now to nearly \$40,000.—*N. Y. Med. Journal*.

Dr. Cotton of Meadville, Pa., has favored the *Cleveland Medical Gazette* with the following translation of an epigram written by Cordus in the sixteenth century, which illustrates the estimation in which men held the medical profession three hundred years ago.

"The physician like an angel seems;  
When he in the sick room brightly beams;  
And like unto a God is he,  
When he has removed the malady.  
But in a different light we view  
The doctor when his bill is due;  
Our altered eyes we at him level,  
As though he was the very devil."



Original Articles.

A CASE IN WHICH THE PLACENTA WAS ADHERENT IN SUCCESSIVE LABOR.

BY W. W. WINSEY, M.D., OF BALTIMORE.

On the 3rd of September, 1882, I was called to a woman who had shortly before been delivered of a living child at full term. The midwife finding the placenta did not come away and that the woman was flowing pretty freely, said she made such compression over the uterus and traction upon the cord as she thought safe; the placenta not yielding she advised the calling of a physician. I found the patient to be a large finely developed woman of 35, weighing about 150 pounds, and was told that this was her seventh labor, and that with five of which there had been trouble in delivering the placenta. I thought likely the midwife had not used sufficiently strong compression over the uterus and traction upon the cord. I therefore grasped the uterus firmly in the right hand, made strong compression, and with the left made what I thought safe traction upon the cord. I thought I felt that peculiar yielding of the cord which accompanies the slipping of the placenta out of the uterus into the vagina, but to my mortification I found I had broken the cord, and as the hæmorrhage increased, without further ceremony I introduced my hand into the uterus, peeled off the adherent part of the placenta and delivered it without further trouble; the hæmorrhage promptly ceased, the uterus contracted and the woman made a good recovery.

About one year after this occurrence I was engaged to attend this same woman in labor, having advised her husband of the danger of trusting his wife in the care of a midwife and probably not being able to get competent medical assistance in case of a similar trouble which seemed highly probable in view of her past experience. The labor was perfectly normal until after the delivery of the child, when I found upon exami-

nation that the placenta was adherent as in her previous labor. As she was having hæmorrhages I judged the placenta was only partially adhered. As before, I gave her chloroform sufficient to enable me to introduce my hand without giving any appreciable pain, peeled off the adherent portion of the placenta and delivered it without further trouble, and as before, the hæmorrhage ceased, the uterus contracted and the woman made an uninterruptedly good recovery.

On the 29th of August, 1885, nearly two years after the last described labor I was summoned to this woman, again having been engaged to attend her.

I found her having moderately strong pains at intervals of 10 to 15 minutes. The os was dilated to about the size of a silver half-dollar, with the membranes intact. Her physical condition appeared as good as in the previous labors in which I had attended her, but she was much oppressed in spirit and expressed fear and apprehension with regard to the final issue of this labor. I tried to cheer and encourage her as best I could, dwelling particularly upon her good fortune in previous labors, notwithstanding the trouble in delivering the placenta. Soon after my arrival the pains grew weak and inefficient and at the expiration of 3 or 4 hours the labor was but little, if any, advanced to what it was upon my arrival; added to this she was anxious and apprehensive at what seemed to her the very slow progress of the labor. I therefore gave fluid ex. of ergot, which soon eased a little of the pain, and in the course of an hour she was delivered of a healthy living child. I soon found I had another adherent placenta to deal with. I pursued the same course as in the previous labor, except the chloroform, which I did not think of until I needed it and then found I had neglected bringing it; in lieu of this I give her about two ounces of whiskey, and in a few minutes afterwards introduced my hand into the vagina, but upon trying to get it into the uterus I found that organ so firmly contracted, at least it seemed so to me, (I was suffering at the time from a

subacute attack of rheumatism of both arms) it was with difficulty that I succeeded in introducing my hand into the uterus and then I could barely move my fingers. Finding I was unable to reach the adherent portion of the placenta, I sent hurriedly for Dr. B. F. Leonard, whose office was not very far off, and to whom I had previously spoken of this woman, her history and expected labor; during the absence of the messenger the flow of blood which had been moderate, increased and became to me, in my physically weak condition, alarming (though I afterwards satisfied myself that it was not excessive). I therefore reintroduced my hand into the uterus and with strength that was begotten of anxiety for my patient's safety I succeeded in reaching the placenta, detached the adhesion and brought it away in pieces just as Dr. Leonard arrived. He, at my request, introduced his hand and confirmed my belief that the placenta had all been removed; the hæmorrhage promptly ceased upon the delivery as is the rule. We washed out the uterus with a solution of permanganate of potash. But the woman did not rally after the delivery of the placenta, and showed unmistakable signs of shock, but from my previous experience with this woman I felt hopeful. Stimulants were given and warmth applied, and such other means as the surroundings afforded were availed of, but to no purpose, and at the expiration of four hours after the delivery of the placenta she died.

Various causes have been assigned by different authors for these abnormal adhesions of the placenta. Some attribute them to "a fibrous transformation of the cellular filaments, which hold the placenta and uterus together whereby they acquire a degree of solidity sufficient to withstand the uterine forces; others say they are the result of an inflammation of the placenta on the uterine wall during gestation which is terminated by the exudation of plastic lymph between the contiguous surfaces." Caszeaux believes they are caused by the fibro-fatty degeneration and atrophy of the villi of the chorion and the cotyledons which they form. But

whatever the cause, some women, as in the case of my patient, seem peculiarly liable to this accident, which always adds gravity to a process which though physiological borders so closely upon the pathological that it can never be said to be entirely devoid of danger. I think the best authorities substantially agree that the treatment should vary according to whether the adhesions are simple or complicated with hæmorrhage. In the former we are advised to use such means as are best calculated to stimulate the uterus to strongly contract and wait with the hope of getting a spontaneous delivery of the placenta, with the latter not to unnecessarily waste precious time, but to anæsthesise the woman, and if possible introduce the hand and deliver the the placenta.

### Society Reports.

#### BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

STATED MEETING HELD APRIL 11, 1886.

(Continued from last issue.)

The President, GEORGE W. MILTENBERGER, M.D., in the chair. WM. E. MOSELEY, M.D., Secretary.

DISCUSSION ON DR. CHUNN'S CASE OF OVARIOTOMY WITH SUPRA-VAGINAL AMPUTATION OF THE UTERUS.

*Dr. H. P. C. Wilson* said he was absent at the last meeting of this society when Dr. Chunn's paper describing the removal of an ovarian tumor from a negro woman was under consideration. As this operation was done at the Hospital for the Women of Maryland under his service, and by his assistant, he would be considered as endorsing the correctness of the case as reported, should he hold his tongue.

He now rose to protest against this case going on record as an ovarian tumor in a negro woman. It was clearly to his mind, a tumor of the uterus. It grew from the whole posterior surface of the uterus as low down



as the vaginal junction. It grew from the fundus uteri and also from the upper part of its anterior surface. It was attached to the left broad ligament and the left ovary. The tumor, the uterus, the left broad ligament and left ovary, were so inseparably blended in one mass, that he thought Dr. Chunn wisely decided that the only hope for the woman was to remove the uterus with tumor and left broad ligament and ovary, as low down as they could be clamped. This he did with the recovery of his patient. At the close of the operation Dr. Chunn requested him to adjust his chain hysterectomy clamp, prior to cutting away the mass, and in performing this act he had ample opportunity to observe accurately the growth of the tumor from the uterus and its adjoining attachments, and he was *then* satisfied that the tumor was uterine in its origin and growth, and he is equally satisfied *now* that it was a cysto-sarcoma of the uterus, and not an ovarian tumor. Although he had examined a great many negro women, he had never seen an ovarian tumor in one. He had consulted a great many physicians on this point and hadn't ever found one who had seen an ovarian tumor in a negress. He had never heard or read of this kind of tumor being found in the African race. Dr. Atlee mentioned such a tumor as occurring in a woman three-fourths white, she was certainly not a negress. Dr. Chunn's operation was performed on December 22, 1885, and the patient died on April 24, 1886, after she had entirely recovered from the operation and had been walking about the city for several weeks. Dr. W. T. Councilman, pathologist to the hospital, in his report of the post-mortem says, that he "found nodules on the surfaces of the liver and spleen, and all over the peritoneal surfaces. The omentum was rolled up into a solid cud as large as a child's arm. It extended into the pelvis and formed part of the mass found there. Microscopical examination proved the nodules to be sarcomas. It seemed certain that none of the tumors could be regarded as primary. It is probable that the origi-

nal tumor, which was removed by Dr. Chunn, was a sarcoma or had some sarcomatous tissue in it."

Dr. W. T. Howard said that he differed entirely from Dr. H. P. C. Wilson in regard to the diagnosis of the case under discussion, and was as positively certain as he could be in respect of any diagnosis whatever, that the case was one of *ovarian* cystoma. At the Woman's Hospital there is a law requiring that no capital operation can be undertaken in the hospital without consultation between the surgeons in charge. In obedience to this law, Dr. Chunn brought the woman to Dr. Howard's clinic. There were present Dr. H's. assistants at the hospital, Drs. Chas. H. Riley, Chas. O'Donovan, Jr., and also Drs. Chunn and L. Ernest Neale. Each of these gentlemen carefully examined the case, and all agreed that it was one of *fibro-cyst of the uterus*. Dr. H. dissented and expressed the opinion that it was an *ovarian cystoma*. Dr. Neale requested Dr. H. to give the reasons for his opinion, and Dr. H. did so. It was well-known that the frequency or infrequency of a disease is a matter of great importance in questions of difficult diagnosis, and that when one disease is frequent and the other proportionally rare, the physician naturally inclines to a diagnosis of the most common affection. But that as, in the negro race, ovarian cystomata and uterine fibro-cysts are almost equally among the rarest of all race affections, infrequency of occurrence as an element of differential diagnosis is not available. Still, it is a well-established fact that *ovarian* cystomata are every where much more frequent than uterine fibro-cysts; hence in any case in which the diagnosis is narrowed down to these two affections, the chances are in favor of *ovarian* disease, unless they are impaired by some other clinical data that may be fairly considered as an off-set. But Dr. Howard knew of no such considerations that could be advanced in this case; on the contrary they rather increase the evidence in favor of the case in hand being *ovarian*. Thus, we all know that the *rate of growth* in the

two affections is, in an immense majority of cases, very different, and that uterine fibro-cysts usually grow much more slowly than ovarian cysts. In Dr. Chunn's case, about three years had elapsed since the woman had noticed that her abdomen was gradually enlarging from below upwards, and then measured fifty inches in circumference around the largest part of the abdomen, and certainly it is *not uncommon* to observe ovarian cystomata developed to such a size in three years, while on the other hand, it is *very uncommon* for a uterine fibro-cyst to attain such a size in the same space of time. Again: the age of the patient militated strongly against its being a uterine fibro-cyst. Thus, of 28 cases of fibro-cysts of the uterus cited from various authors in Dr. Howard's address before the American Gynecological Society in Washington City, in September last, only four were under 34 years; generally they were from 40 to 50. The only case of fibro-cyst of the uterus that Dr. Howard had seen published as occurring in a woman as early as 24 years of age, was one reported by Dr. Hunter McGuire in the second volume of the *Philadelphia Medical Times*. But Dr. Chunn's case was only 20 years of age. Has Dr. Wilson ever seen or heard or read of any case of uterine fibro-cyst occurring at that early age in any woman of any country, race or condition in life? But who is it that does not know that ovarian cystomata are *common at that age, and long before*? And Dr. Howard repeated that in respect of frequency of occurrence, whether in this country or abroad, it is a universally admitted fact, a fibro cystoma of the uterus, in comparison with an ovarian cystoma, is a *very rare disease at any age*. In his immense experience, embracing more than 1000 laparotomies, Lawson Tait has only once seen a fibro-cystic tumor of the uterus.

Now let us consider what light the operation threw upon the question at issue. When Dr. Chunn had cut down upon the cyst, what *color* did it present? It is well-known that a dark and con-

gested appearance is characteristic of a fibro-cyst of the uterus, and that it strongly contrasts with the clear, pearl-like conjunctival blue of most ovarian cysts. And so typical was the appearance of an *ovarian* cyst in Dr. Chunn's case, that when Dr. Wilson saw it he said: "Howard, I believe your diagnosis is right." When the fluid was drawn off, it presented the dark, chocolate appearance and unctuous character so often seen in ovarian cystomata. But when Dr. Chunn drew out the cyst, Dr. Wilson re-asserted his original opinion that it was a fibro-cyst of the uterus. Dr. Chunn hesitated what to do, but finally removed the uterus somewhat above the junction of the cervix with the corpus. Dr. J. Edwin Michael, *Professor of Anatomy* in the University of Maryland, then carefully examined the specimen and demonstrated to the entire satisfaction of all the physicians present who had diagnosed the case as a uterine fibro-cyst, that they were completely mistaken, with the single exception of Dr. Wilson, and that it was an *ovarian cyst*. When the specimen was subsequently exhibited before the *Clinical Society of Maryland*, Professor Michael said: "An examination of the specimen will show that the uterus is free from adhesions to the tumor on both its anterior and posterior surfaces, and is only connected with it by means of adhesions of the broad ligament. The tumor, in other words, having its proper pedicle on one side, had become adherent to the broad ligament on the other side, and these adhesions could have been ligated and cut, and the tumor removed, as is usual in such cases, with less danger to the life of the patient than that in which she was exposed in the operation done.\*" And, as Dr. Howard was informed, there was not a dissenting voice in regard to the diagnosis of *ovarian* cystoma among all the physicians present, who saw and examined the specimen. Thus it appears, that all the physicians who saw the woman before the operation was done and committed them-

\*MARYLAND MEDICAL JOURNAL, April 24th, 1886, p. 503.



selves to the diagnosis of a fibro-cystic tumor of the uterus, and were subsequently present at the operation and personally examined the specimen, frankly confessed that they were mistaken in their diagnosis and that Dr. Howard's diagnosis, from the first to the last, was correct, with the sole exception of Dr. Wilson, who stands solitary and alone in his erroneous diagnosis. And, further, that all the physicians at a meeting of a large medical society, who had never committed themselves to any diagnosis, and only saw and examined the specimen, were as one in the diagnosis of *ovarian cystoma*. As to what Dr. Councilman found in the dead body of the woman four months after a protracted and nearly fatal illness, that has obviously nothing to do with the accuracy of the diagnosis at and before the operation, for, certainly, no one who witnessed the operation can say that, with the exception of the cyst removed by Dr. Chunn, there was any evidence whatever of any morbid condition in the abdomen and pelvis.

Dr. W. P. Chunn said that having reported the case under discussion as an ovarian tumor, which diagnosis having been questioned he would give his reasons for the opinion he then held and still continues to hold. The whole history of the case pointed to ovarian disease, viz., the short time of growth (three years), the youth of the patient (20 years), the shape of the abdomen and the area of dullness and fluctuation. The facies ovariana was strongly marked. Moreover, when the abdomen was opened, there appeared a cyst of a *glistening pearl-like hue* containing a pathognomonic thick, *chocolate colored* fluid, which did not coagulate. These signs were given in every book on the subject he had ever read as certain and undoubted evidence of ovarian cyst. In regard to taking out the uterus he wished to make himself equally plain. The uterus was imbedded in the anterior wall of the sac, as he had before said, and was attached by the posterior and left lateral aspect, the right border only being free. All those who saw the pelvic relations *in situ*, viz. Drs. O'Dono-

van, H. P. C. Wilson and himself agreed that the attachments were of the most intimate character. The opinion of the other gentlemen present was derived from the relations of the tumor to the uterus *after extirpation*, as they had no opportunity to inspect the relations while in the pelvis. Their opinion was incorrect, and for the following reason: When the uterus and sac were cut away in order to leave plenty of tissue in the bite of the clamp, the amputation was begun far up above the chain and was made in an obliquely downward direction, so that when the sac was at last taken away, only the left horn of the uterus went with it, the rest of the uterine tissue being trimmed away afterwards. This occurred because the chain of the clamp was hidden from view by the over-lapping parts, and again, the uterus and sac being lifted up by an assistant as the cuts were made by scalpel or scissors at *different* distances above the clamp, the parts all spread out in such a manner that the relation of the uterus to the sac was simply impossible to be made out *after removal*. At the time of operation he was of the opinion that those present were in favor of hysterectomy; certain it is that no dissenting voice was heard until after the operation was completed.

Dr. W. E. Moseley was present at the meeting of the Clinical Society at which Dr. Chunn reported his case and exhibited the specimen. He had carefully examined the specimen and had no doubt but that it was an ovarian cyst and he felt certain that was the opinion of all who examined the specimen, among them being Drs. Keirle, Councilman and Tiffany. He did, however, consider that, *judging from the specimen shown*, the operation *as done* was not justifiable, as he believed the cyst could have been ligated and removed without involving any portion of the uterus.

Dr. Chas. O'Donovan, Jr., said he too wished to add a few words in regard to this case. Dr. Chunn requested him before the operation to stand opposite him and sponge, which he did during the entire operation, so that after him he had the best opportunity of any-

one to see the condition of the parts in the abdominal cavity before the removal of the tumor, and he could state without hesitation that before the tumor with uterus had been cut away, it was next to impossible to make out the exact amount or the locality of the attachments that existed. He knew Dr. Chunn had been very severely criticised in his method of operating, by those especially who saw the tumor for the first time after it had been removed from its surroundings, when the cut edges of the enormously thickened broad ligament could be turned back, thus exposing the tumor from below, and giving a clear view at once of the location of the pedicle and its extent, but he desired to say in defence of Dr. Chunn that the view he had of it during the operation and from above was very apt to mislead. The tumor in developing had gradually spread out the broad ligament and pushed it before it, being all the while intimately connected with its inner surface, so that to say at the time of the operation, when through the escape of the contents of the cyst mixed with blood the appearance of the different tissues in the cavity had become very indistinct, where the exact ending of the broad ligament lay on the cyst wall, was next to impossible. In more than one operation that he had witnessed he had seen the same thing happen, but usually, by very careful inspection, it was possible to make out the line of junction, when by cautiously peeling off the ligament the cyst could be shelled out as it were from its covering. From the criticisms made upon this case one might infer that Dr. Chunn hastily applied the clamp and cut off the uterus without making any examination of attachments whatever, but nothing could be further from the case; he very carefully went over the mass more than once both in front and behind but nowhere could he make out the line of junction. It was only then that he determined to do a hysterectomy, in preference to cutting away the great mass of the tumor and leaving part of the cyst behind. After the operation when Prof. Michael had demonstrated that the tumor was not attached directly

to the uterus, as was apparent from the view beneath the broad ligament, it seemed plain to all, except Dr. H. P. C. Wilson, that the uterus should never have been removed, but he would repeat that until that moment it was impossible for anyone to say for certain what was the attachment of the tumor. One word for the diagnosis. Before the operation, as Dr. Howard had stated, he and all who saw the case, except Dr. Howard, inclined to the diagnosis of fibro-cyst of the uterus, but with a considerable margin of doubt; after the operation we all, except Dr. H. P. C. Wilson, conceded that we had been wrong and that the tumor was ovarian.

#### A NEW TOURNIQUET.

*Dr. A. F. Erich* exhibited a new tourniquet he had invented for the temporary compression of the stump in supravaginal amputation of the uterus. The tourniquet has the usual male and female screw, but the canula is made somewhat heavy and the eye at the end large enough to allow the loop of a rubber tube the size of the little finger to be passed through. The ends of this rubber tubing, which is used in place of wire or cat-gut, are tied together and hooked over a stout hook attached to the shaft of the instrument. By this arrangement the tubing can be repeatedly loosened and tightened without the annoyance and delay by tying and untying the knot, or danger of bruising the parts.

The general impression of the members present was that the instrument would prove a very useful adjunct in the cases for which it was intended.

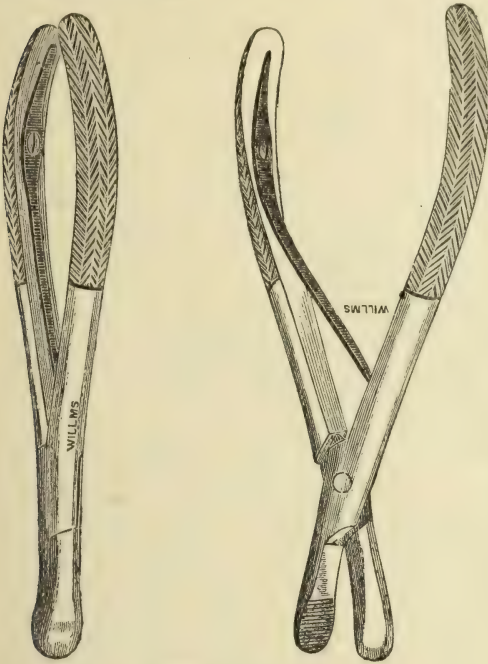
#### A NEW FORCEPS FOR COMPRESSING SHOT.

*Dr. Robert T. Wilson* exhibited a forceps for compressing shot to be used in any plastic operation in which shooting the sutures was desired.

The general opinion expressed was that the forceps were unnecessarily heavy and the jaws too wide, as they



would be apt to hide the suture they were fastening.



### Correspondence.

#### THE PHYSICIAN AND LITERATURE.

*Editor Maryland Medical Journal.*

DEAR SIR:—That a great amount of ignorance exists in our profession on the above subject is well known. To be convinced of the fact one need only make a few inquiries. It may seem incredible, but only recently I heard a doctor and another person trying to decide whether William Cullen Bryant was dead.

It is well known and is often remarked that physicians as a class do not occupy as high a position socially as do lawyers and ministers, and may not this be accounted for almost entirely because of the ignorance above named?

Most doctors think, or at least act as though they think, that to be well posted in the various branches of medicine and surgery (and in these latter days they limit themselves to one branch called a specialty) is the only literary requisite for professional success. The hours not occupied with professional

work are devoted entirely to medical journals and books. No time is given to languages, mathematics, philosophy, or literature. Some do not even read the daily press (which by the way is probably less important than any of the subjects named).

Is it any wonder then that we do not like society and that society does not like us?

It is just about as interesting for the person trying to converse with us on general subjects and books, as it is for us when talking to a new medical student about physical diagnosis. It is all one sided. The public is wearied and we as a class are not considered at all important to the success of a social gathering.

We try to convince ourselves that we are not the worse in practice, but we are. We may have as large a call list and see as many patients, but they are of an inferior class. We cannot and do not attain the best practice, unless we accord with the tastes thereof. Medical knowledge and skill are important factors in every physician; but the greater number of patients do not need these.

They are not very ill, they need little or no medication. If this were not so, how could men without these qualities succeed, as they evidently do.

"Mental therapeutics" has been sadly neglected. More persons being ill mentally than physically, should teach us to study mental therapeutics the more.

If such is the case, and I'm sure it cannot be denied successfully, our armamentarium is incomplete though we have all knowledge in medicine and drugs.

We must have some "balm of healing" for the mind. Where can we obtain it better in quality, variety, and utility than in the field of general literature. Fiction, history, biography, humor, poetry, essays, critiques, etc., are all found here.

Dr. Nillard thinks that every physician should be well acquainted with the following six branches in addition to his medical knowledge, namely: languages especially English and Latin; natural history, especially zoology and

botany; mathematics, philosophy, rhetoric and logic; and general literature. He also suggests geology and mineralogy.

The objection will be at once urged, lack of time. I admit its validity. Very few men are like Cuvier, John Stuart Mill, Gladstone, and others, who are masters in many departments. We cannot be up to the times in medicine, and well-informed in the six or eight subjects named by Dr. Nillard, and at the same time do a large general practice. But I make claim and plea for only one branch; that of most general value and application—*general literature*.

We can be quite well informed in this department at a small outlay of time and money. Many works of fiction, biography, history, poetry, etc., are now issued in cheap, convenient, and readable form. Only recently, Cassell & Company of New York have begun a series called the "National Library" at ten cents per volume. These books are about four inches wide, five and a half long, and one-half thick. They can readily be carried in a coat pocket, or where "ye olden doctors" carried the handkerchief—in the hat.

Many hours of one's life are wasted in cars, at depots, waiting for consultants or other tardy people, which can be profitably used by having at hand a volume similar in kind to the one above named.

Then it will be necessary to take a literary journal just as we do a medical, in order to know what is going on in the literary world. There is none, when viewed in all ways, more suitable for a physician thus keeping himself acquainted with literature, than "*The Critic*." It is published weekly at New York, and costs but three dollars per year. I have no doubt it could be gotten with any good medical journal (by the "clubbing rates" now in vogue) at even less cost. Having read it carefully for a long time I feel that I cannot too highly commend it to my fellow practitioners. It contains just what we men need, who are in a hurry and must get a great deal in a small compass. It opens with an article not very long, on some important topic, such as "the adjective," "the noun."

Then the *reviews* of all recent books. These are remarkable in that, they read as though the writer had really and carefully read the book, which is quite unusual with reviewers; we are told; notes of what the last magazines contain; some bits of poetry scattered here and there; letters from London and other large cities as to what is transpiring in art, music, the drama and letters; art, dramatic and musical notes from our large cities; general and personal notes; current criticism; from one to three selected articles on some literary subject; a free question box; and the lounge. I cannot begin to tell the value of what the lounge says; you must read to fully appreciate.

One more necessity, and in my opinion a physician is prepared by a reasonably small amount of time, to be well posted in general literature, and that is one of the standard "Reviews." They are in this country (and I don't believe in patronizing foreign when our own products are the equal if not superior), four in number, the "*North American*," "*New Princeton*," "*Andover*," and "*Forum*." The last is a new one, having made its first appearance in March. I need say nothing of the first three as they are so well known. Probably the "*North American*," and the "*Forum*" have less of a religious cast than the other two. The *Forum* is edited by Mr. Metcalf who so ably and successfully conducted the first above named. If we may judge from the two numbers, which we have carefully examined, it will be more popular and more suitable for the purpose of this plea than any of the others.

Why take a review at all? In order to get the idea of our ablest thinkers on the important topics and questions of the day, such as labor and capital, the negro question, religious beliefs, doctrines, etc., questions of science, education and state.

In the foregoing we have endeavored to indicate the importance—and if we wish to stand equal in society to the lawyer and minister—the necessity of such an acquirement in addition to our medical education,



Such a course carefully followed will not only cause us to rank where we ought, to obtain a pleasant and elegant practice, but will enable us to express ourselves on paper in a proper and correct manner.

The amount of bad composition, orthography, and grammar among medical writers is appalling.

Nor is it confined to young or ignorant (medically speaking) men. I am assured that the chief burden of an editor's position is the arrangement of the matter sent in by physicians, into proper form for publication. No matter sent by a physician for publication to *any* journal ought to need correction. The way to attain this accuracy is not by neglecting everything but medical literature.

We therefore plead with every doctor to pause a moment, and think of these things. If you find no time for *many* things except professional study and practice, devote yourself at least to *one*—general literature.

Yours Truly,  
MEDA.

### Hospital Reports.

#### REPORT OF THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

BY JULIAN J. CHISOLM, M.D., SURGEON  
IN CHARGE.

WORK AT THE HOSPITAL FOR THE WEEK  
ENDING MAY 22ND, 1886.

New cases admitted to Hospital during week, 158; old cases treated during the week, 681; operations during the week, 50, among them

Cataract extractions, - - - -	7
Enucleations, - - - -	6
Squint operations, - - - -	7
Iridectomies for closed pupil, - - -	2
Removal of humors, - - - -	5
Removal of pterygium, - - - -	2
Removal of nasal polypi, - - - -	2
Amputation of Ear for Cancer, - - -	1
Splitting the Canaliculus for tear drop,	3
Removing fish bone from throat, - -	1
Removing foreign bodies from cornea, -	4

The admission of new cases for the past four months, from 1st January, 2,653.

The after treatment of cataract patients in the Presbyterian Hospital has undergone a total change of late. The eyes are no longer covered up with cotton compresses and bandages, but are closed with a piece of isinglass plaster as the sole dressing. This is removed on the sixth day. Dark rooms are no longer used, light enough is admitted to enable one to read with ease in any part of the room. The patients are not confined to bed after the first twenty-four hours, but can sit up at their pleasure. These changes form a total revolution in the treatment of cataract cases. It removes the chief item of annoyance—confinement and constraint in the dark for two weeks. The eyes operated upon and treated in light rooms escape the photophobia engendered by the former method of confinement in the dark with thick compresses over the eyes. This very recent improvement in the treatment of cataract cases promises to be one of the most valuable contributions to eye surgery.

THE SURGICAL TREATMENT OF CHRONIC ECZEMA.—Dr. Max Bockhart recommends the following drastic treatment in chronic eczema. The crusts having been removed, the whole affected surface is scarified with a double-edged lancet in two directions at right angles to each other. After the bleeding has been checked, the surface is rubbed with wadding or charpie, soaked in solution of potash, until the upper thick epidermic layer begins to loosen. Then the potash solution is washed off, and the surface covered with diachylon ointment or olive oil. After twenty-four hours the dressing is removed, and a water-compress applied. The appearance then resembles an ulcerated surface, and the part is dressed, once in three days, with pyrogallic ointment or solution of nitrate of silver. The cure is complete in fourteen days to four weeks. Relapses do not occur, and the elasticity and flexibility of the skin are not affected.—*London Medical Record*, April, 1886.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, MAY 29, 1886.

**Editorial.**

**THE MODERN TREATMENT OF UTERINE CANCER.**—In no field of surgical practice, perhaps, has greater progress been made in recent years than in the surgical treatment of uterine cancer.

By gradual steps an almost hopeless malady has been wrested from neglect and has been made to pay tribute to the skill and ingenuity of the surgeon's knife by procedures as original in conception as they are daring in their execution. The results of the operative procedures instituted for this disease may be considered brilliant in contrast with the medical treatment of these cases formerly almost exclusively employed. The earlier efforts to remove cancerous tissue from the cervix and body of the uterus were so limited in their application that few patients, comparatively speaking, were benefitted by them. The curette and cautery undoubtedly rendered efficient service in arresting the progress of the pathological growth, and in controlling hæmorrhage for the time being, but the dreaded fear of the peritoneum put a check upon any procedure which aimed to be radical in its results. Unless the cancerous growth was observed in its earliest manifestation surgical treatment was regarded as scarcely more than palliative. As surgeons have been liberated from the terror inspired by the peritoneal membrane bolder methods have come into practice. The surgeon now not only dares to treat the uterine cancer

by high amputation, but has extended his methods of procedure to total extirpation of the uterus. Within the last decade the literature of this subject has grown enormously, and with this growth of knowledge most striking facts have been adduced to support the value of the various operative methods employed for the radical cure of this affection. To our fellow-countryman, Dr. W. H. Baker, of Boston, belongs the chief credit for perfecting the method of treating uterine cancer by the high amputation. Dr. Baker first described his method in April, 1882, and then fully explained the steps of an operation which has since been practiced by a number of surgeons. At that time Dr. Baker reported ten cases in which his operation was done in its completeness prior to this date. Of these ten, eight were reported living and well in April, 1882, after a varying interval from the disease of from four years to a few months. To prove the value of any radical method of procedure for the cure of cancer, the subsequent history of the cases operated upon is important. This history is now furnished by Dr. Baker. In a paper read before the "Alumni Association of the Woman's Hospital, in the State of New York," January 20, 1886, (see Transaction, volume I. D. Appleton & Co., New York) Dr. Baker reports the subsequent history of these cases. Of the eight cases living and well in April, 1882, six are now living and apparently well, and five of the six show absolutely no return of the disease. Thus after a lapse of over four years we witness results which argue strongly in favor of this radical operation for the removal of cancer, as also in favor of considering the disease one of local origin. In the cases reported the diagnosis of cancer was made sure, not only by the gross appearances, but by microscopical examination. An equally gratifying fact is found in the circumstance that no death occurred from the immediate effects of the operation. Dr. Baker is confident that quite as much of the ultimate success in high amputation is due to the subsequent following up of the case as to the primary



operation. In the cases cited, with but one exception, repeated use of the curette and cautery were required. In summing up the advantages of the high amputation Dr. Baker offers the following :

1. That by it we are able to remove more of the uterus than by any other form of high amputation.

2. The opening of the peritoneal cavity is not necessarily involved in its performance.

3. The practicability of using the touch in determining the extent of the disease as the operation proceeds is retained, which can not be practiced when the galvano-caustic wire is used.

4. All the advantages of the galvano-cautery are retained by the application of the thermo-cautery, at a red heat, to all the denuded surfaces, and made more effectual even by previously being sure that the disease, as evidenced by the touch, had been removed.

5. It is more practicable for the general surgeon than total extirpation.

6. The length of respite from the disease is greater than in any reported cases of total extirpation, and the percentage of recoveries from the operation greater than by any other method of high amputation.

Turning now to the method of total extirpation we are able to record results equally creditable to surgical boldness and skill. That this operation has its appropriate field no one can doubt, but a practical question must arise in determining the method of procedure to be adopted in any case under consideration. In comparing the results of the high amputation with those of total extirpation due consideration must be given to the location of the cancerous growth. It is not fair to place these methods upon an equal footing. Each has its limits of application and must be viewed from its respective standpoint. The mortality of total vaginal extirpation of the uterus is undoubtedly high. Gusserow has collected 253 cases with a mortality of 23.3 per cent. Olshausen, out of 25 cases of complete extirpation, had seven deaths; two on the day of operation, three from septicaemia on the second and third day, one from carbolic

acid poisoning on the second day, and one from iodoform poisoning on the sixth day. Since this report was made in 1884, he is reported to have had nine cases without a single death. As statistics accumulate and the experience of the most frequent operators grows the mortality from total vaginal extirpation shows a most striking decrease. With these facts in view the advocates of the methods of partial and of total extirpation do not agree in respect to the respective merits of the two procedures.

The object of surgical interference is undoubtedly to effect a radical cure with the least danger to life by the procedure adopted. The high amputation has thus far a mortality one-fourth less than the method of total extirpation, but it is claimed by those who favor the latter procedure that though the death-rate following this operation is high, the chance of immunity from recurrence is small. Upon this point, however, statistics are not yet available. It seems to us that the results of all operative methods must depend upon the conditions present in a given case rather than upon the choice of the method to be adopted. We must doubt the justifiability of an attempt at total extirpation with its attendant risks in a case of cancer limited to the cervix, even though this method promises a greater immunity from recurrence. On the other hand, high amputation can scarcely be deemed a radical procedure when the cancerous growth has extended to the fundus and involves the entire organ. To advocate one procedure to the exclusive of the other without regard to the extent and location of the malignant growth is about as radical as it is illogical.

LAPAROTOMY FOR OBSTRUCTION.—Attention was called some weeks ago, in these columns, to the growing tendency to invade the abdominal cavity under various contingencies which formerly would have been considered insufficient justification for so grave a procedure. A few years ago abdominal surgery was considered the almost exclusive domain of gynecologists, and there is no doubt that we owe them much gratitude for what

they have taught the general profession in regard to the surgery of the peritoneal cavity. The valuable papers by Dr. N. Senn, of Milwaukee, before the American Medical Association, Dr. C. Johnston, Sr., of this city, before the American Surgical Association, and Dr. R. Winslow, before the Medical and Chirurgical Faculty of Maryland, give some indication of the attention general surgeons are giving the subject. The treatment of obstruction of the bowels is a subject of peculiar interest, in that there is great need of agreement between medical men and surgeons in regard to it. When a patient is shot or stabbed in the belly he naturally falls into the hands of a surgeon, and is treated from the first according to surgical views. When there is a tumor to be considered the medical man does not undertake its management. But when a patient fails to have proper movements of the bowels, he naturally seeks medical advice, and the interesting point is when shall the physician cease the use of drugs and enemata and ask for surgical aid. The main point of difficulty in arriving at an agreement is the impossibility of making an accurate diagnosis of the cause of the obstruction. While some hope might be entertained of reducing a volvulus or an intussusception by "abdominal taxis," as advised by Jonathan Hutchinson, or forced injections, as recommended by Illoyay, of Cincinnati, and others; the most timid and conservative doctor could not fail to advise operation in a case of stricture, internal strangulation or peritoneal band. But in a great majority of cases we are unable to be sure of the cause of the trouble, and while we wait and cogitate about it the patient dies. When medical men become convinced that, as a rule, a continuation of the obstruction is much more perilous to the patient than opening the belly with proper precautions, they will begin to give to the surgeon an earlier and hence a better opportunity to save the patient's life. Physicians are prone to look upon laparotomy as a last resort and almost equivalent to a fatal termination, and hence the surgeons complain that they

do not have a fair chance in operating. They only see the patient after many days of obstruction, with much distension, greatly exhausted by the use of drastic purges and large injections, with perhaps a commencing peritonitis, and in the worst possible condition to endure a severe operation. We are convinced that earlier operations would give better results. Dr. Johnston, in his paper on "Diagnostical Laparotomy," shows the comparative harmlessness of an exploratory incision, and if medical men could be brought to understand this, many grave doubts, upon which hang the lives of patients, could be resolved. Notwithstanding the difficulties under which laparotomy for obstruction labors, it has yielded results which give it no mean surgical standing. Dr. Senn gives the results of the 190 cases collected by Schraum, as showing 73 per cent. mortality before the introduction of antiseptics, and only 58 per cent. since. If we are correctly informed, there have been six laparotomies for obstruction done in our city during the past year, with two recoveries; and these, as well as all the fatal cases, showed lesions which could not possibly have been relieved by medicine. It must be remembered that these results are to be compared with almost certain death, which ensues when operation is declined. It is certain that the operation is gaining ground, and we are convinced that the more the attention of the general profession is attracted to it, and the more clearly the indications for it are understood, the more frequently and successfully will it be performed.

THE HOSPITAL OF THE GOOD SAMARITAN.—The existence of this institution is perhaps unknown to the majority of our readers, and even in this city many of the profession are unacquainted with its location, and the objects for which it was founded. This Hospital was opened for the reception of patients on Oct. 1st, 1885, and has been doing a quiet, but beneficent work since that date. The Hospital building is a fine old mansion, enclosed within a square of ample grounds, adorned with flower beds and



beautiful shade trees, and located between McCulloh Street and Druid Hill Avenue, and McMechen and Mosher Streets. Within the building there is an entire absence of those unpleasant associations which are the usual concomitants of public institutions for the care of the sick. The wards are well ventilated and entirely free from unpleasant odors. In the white female ward most of the beds are enclosed by curtains in such a way as to divide the space into separate compartments, so that the patients can enjoy almost as much privacy as if they were in private rooms. For those who desire private apartments, several elegant chambers, handsomely fitted up, can be obtained upon reasonable terms. The Hospital of the Good Samaritan is a non-sectarian institution for the reception of all non-contagious diseases. It is conducted by a board of lady visitors, of which Mrs. John K. Cowen is the President, and the staff of physicians and surgeons is composed of some of the best known members of the profession in the city. After an extensive experience with the various hospitals in Baltimore, we do not hesitate to say that the Good Samaritan offers advantages which compare favorably with any other general hospital here. The domestic affairs of the institution are under the efficient management of Mrs. S. J. McElroy, a lady who combines marked executive ability with large experience in the care of the sick. Patients who are unable to pay, are received at the expense of the institution, whilst those whose means are limited are taken at very reasonable rates.

### Abstracts and Extracts.

THE SURGERY OF THE PANCREAS AS BASED UPON EXPERIENCES AND CLINICAL RESEARCHES.—In a paper having the above title read before the American Surgical Association by Dr. N. Senn, of Milwaukee. The following conclusions were presented:

I. Restoration of the continuity of the pancreatic duct does not take place after complete section of the pancreas.

II. Complete extirpation of the pan-

creas is invariably followed by death, produced either by the traumatism, or gangrene of the duodenum.

III. Partial excision of the pancreas for injury or disease is a feasible and justifiable surgical procedure.

IV. Complete obstruction of the pancreatic duct, uncomplicated by pathological conditions of the parenchyma of the organ, never results in the formation of a cyst.

V. In simple obstruction of the pancreatic duct the pancreatic juice is removed by absorption.

VI. Gradual atrophy of the pancreas from nutritive or degenerative changes of the secreting structures is not incompatible with health.

VII. Physiological detachment of any portion of the pancreas is invariably followed by progressive degeneration of the glandular tissue.

VIII. Extravasation of pancreatic juice into the peritoneal cavity does not produce peritonitis.

IX. Crushed or lacerated pancreatic tissue is removed by absorption, provided the site of operation remains aseptic.

X. Complete division of the pancreas by elastic constriction is never followed by restoration of interrupted anatomical continuities.

XI. Limited detachment of the mesentery from the duodenum, as required in operations upon the pancreas, is not followed by gangrene of the bowel.

XII. In all operations upon the head of the pancreas, the physiological attachment of the peripheral portion of the gland should be maintained by preserving the integrity of the main pancreatic duct.

XIII. Partial incision of the splenic portion of the pancreas is indicated in cases of circumscribed abscess and malignant tumors, in all cases where the pathological product can be removed completely without danger of compromising pancreatic digestion, or of inflicting additional injury upon important adjacent organs.

XIV. Ligation of the pancreas at the point or points of section should precede extirpation as a prophylactic measure against troublesome hæmor-

rhage and the extravasation of pancreatic juice into the peritoneal cavity.

XV. The formation of external pancreatic fistula by abdominal section is indicated in the treatment of cysts, abscess, gangrene and hæmorrhage of the pancreas due to local causes.

XVI. Abdominal section and lumbar drainage is indicated in cases of abscess or gangrene of the pancreas where it is found impossible to establish an anterior abdominal fistula.

XVII. Thorough drainage is indicated in cases of abscess and gangrene of the pancreas with diffuse burrowing of pus in the retro-peritoneal space.

XVIII. Removal of an impacted pancreatic calculus in the duodenal extremity of the duct of Wirsung by taxis or incision should be practiced in all cases where the common bile duct is compressed or obstructed by the calculus and death is threatened by cholemia.

XIX. In such cases the principal source of danger, extravasation of bile into the peritoneal cavity should be avoided by preliminary aspiration of the dilated bile ducts, accurate closure of the visceral wound with fine silk sutures, and absolute physiological rest of the organs of digestion during the time required in the healing of the visceral wound.

A PRELIMINARY ACCOUNT IN REGARD TO CIRCULATORY AND RESPIRATORY CHANGES OBSERVED IN ANIMALS PLACED IN THE PNEUMATIC CABINET.—At the recent meeting of the American Climatological Association Dr. F. Donaldson, Jr., of this city read a paper with the above title.

The experiments had been performed by Professor H. N. Martin, of the Johns Hopkins University, and the writer. The animals employed were rabbits, which had been chloralized. It was found—

1. When the animal is breathing air from outside the cabinet, rarefaction of air within the cabinet causes a marked fall of general arterial pressure, but has no influence on the pulse-rate. The fall of pressure lasts only a short time (ten to twenty seconds), and is often fol-

lowed by a temporary rise above the normal.

2. This fall of systemic arterial pressure depends on two factors: greater flow of blood to the skin when the air around the animal is rarefied, and greater accumulation of blood in the lungs when they are distended.

3. Of these two factors, accumulation of blood in the lungs is the more effective, for if the animal breathes air from the cabinet, and not from the outside, rarefaction of the air within the cabinet (in this case accompanied by no special expansion of the thorax) has but a trivial effect in lowering arterial pressure.

4. When the animal is breathing external air, rarefaction of the air within the cabinet usually has no effect upon the respiratory rate nor upon the extent of individual respiratory acts, unless the fall of blood-pressure be considerable. If it be considerable, symptoms of anæmia of the medulla oblongata show themselves. In some cases there is more forcible dyspnoic breathing, and, in some, dyspnoic convulsions similar to those which occur when an animal is bled to death, and due to the same cause, viz., deficient blood flowing through the respiratory centre.

5. The rapid recovery of general arterial pressure, while the animal is still in a rarefied atmosphere but breathing external air, is probably due to excitation of the vasomotor centre, which, as is well known, is excited whenever the blood supply is defective.

6. The brain, enclosed in a rigid box which is practically unaffected by variations in the atmospheric pressure, has its circulation more disturbed in the pneumatic cabinet than any other organ, with the exception of the lungs.

7. Compression of the air within the cabinet while the lungs are in communication with the external air, causes a considerable transient rise of blood pressure. This is probably due to the forcing of the blood from the cutaneous vessels, but there has not yet been sufficient time to investigate this point thoroughly.

8. Compression of the air within the cabinet while the lungs are in communi-



cation with the external air, slows the pulse as the arterial pressure rises. This is probably due to excitation of the cardio-inhibitory centre by increased intracranial blood pressure. Further experiments are, however, necessary before this can be positively stated.

9. In certain cases when the air within the cabinet is rarefied and the animal is breathing external air, the respiratory movements cease altogether for several seconds. As to the cause of this physiological apnoea, we are not yet ready to form an opinion. It may be due to extra accumulation of air in the alveoli of the lung, or to distention of the lungs, exciting those fibres of the pneumogastric which tend to check inspiration.

**VULVAR PRURITUS.**—Dr. Martineau has published a lecture (*Annals Médico-Chirurgicales*) upon vulvar pruritus, in which he gives to practitioners certain advice in regard to the best mode of treatment of this painful and rebellious affection. First of all, it is important to ascertain the cause of the disease; for, in order to treat it intelligently, it is necessary: 1st, to treat the constitutional malady, the original source of the accident; 2nd, to treat the lesion, the immediate cause of the pruritus; 3rd, to treat the morbid phenomenon, the pruritus. We should determine whether the patient is tuberculous, lymphatic, neuropathic, diabetic, etc.; then, whether there exist any parasitic affection, as intestinal worms, oxyures, pediculi pudendi, herpes tonsurans; whether there are vesical or urethral disorders, etc.; and the genital organs should be carefully examined, the vulva, vagina, and uterus, since vulvar pruritus is often symptomatic of metritis, of vaginitis, of contagious vulvitis, or it may be consecutive to eruptions of psoriasis, lichen, zona, and especially herpes. Finally, vulvar pruritus may be purely of nervous origin and occur without any apparent lesion of the integument; in nervous or arthritic women, any moral impression, or simple change of temperature, may suffice to develop it.

After this preliminary, but quite

necessary investigation, one is prepared to treat the pruritus intelligently and successfully. A treatment appropriate to the constitutional condition and the local lesion may then be instituted, although, as intimated above, we must rely upon local means to palliate the almost intolerable intensity of the morbid phenomenon. Where there is an acute inflammation, as in vulvitis, emollients, poultices of potato starch, lotions with infusions of belladonna, aconite, or poppy heads should be employed, or a solution of bromide of potassium or chloral. Dr. Martineau recommends that the lotions be applied rather warm than cold. The poultices may be replaced by compresses of fine linen saturated with decoction of leaves of elder or myrrh. When the acute stage has subsided, weak lotions of the sublimate may be employed, two or three times a day. Sometimes slight cauterization with nitrate of silver will be found serviceable; sometimes the application to the vulva of compresses dipped in a slightly acidulated water affords relief. At night, if there is irritation of the integument, it may be smeared over with an ointment composed of 50 grams of glycerole of starch to 1 gram of either tannin, calomel, ext. belladonna or oil of cade, according to circumstances.

In chronic cases, Dr. N. Guéneau de Mussy makes lotions with the following: Infusion of marsh mallow, 1 litre; cherry laurel water, 50 grams; subborate of soda, 10 grams. He then prescribes an ointment to be used night and morning, as follows: Glycerole of starch, 20 grams bromide of potassium and subnitrate of bismuth,  $\text{aa}$  1 gram; calomel, 40 centigrams; extract of belladonna, 20 centigrams.

Delieux de Savignac uses the above lotion, and then dusts the surface with the following powder: Pulv. lycopodium, 30 grams; subnitrate of bismuth, 19 grams; belladonna root, 2 grams. Sometimes good results are obtained by sprinkling the vulva with iodoform.

Since the discovery of cocaine, it has been employed in all painful affections of the mucous membranes, and especially in vulvar pruritus. Dujardin Beau-

metz has been able to obtain a prompt anæsthesia of the vulva by painting the parts with a one-fifth solution of this drug. In my experience, I have found that an almost intolerable pruritus, symptomatic of herpes of the vulva, may be relieved by applications of an ointment of cocaine ( $\frac{1}{16}$  to  $\frac{1}{8}$ ).—*Journal of Cut. and Ven. Diseases*, May, 1886.

INSANITY FOLLOWING GUNSHOT INJURY TO THE HEAD; CEREBRAL CYST; ASPIRATION; RECOVERY.—DR. CARLOS F. MACDONALD records, in the April number of *The American Journal of the Medical Sciences*, this case; which is of particular interest, for the following reasons:

1. A lesion located anteriorly to that portion of the first frontal gyrus included in the centre marked 12 by Ferrier, and which is now regarded as the anterior boundary of the motor area giving rise to physis derangement, and unaccompanied by motory or sensory disturbance, furnishes affirmative evidence, both positive and negative, of the correctness of the view held by a majority of modern neuro-psychologists, namely, that the motor and sensory areas of the cerebral cortex are not located in that portion of the brain lying anterior to the coronal suture.

2 That when not in a state of inflammation, the brain substance may be punctured with a fine, clear needle, with comparative immunity from danger or disturbance of function.

3 The certainty that recovery in this case was directly due to the operation.

4 Cases of insanity dependent upon injury to the head, and accompanied, as they usually are, by mental irritability and explosions of temper, are, as a rule, so seldom benefitted by drugs or the so-called moral treatment, that they have come to be regarded as incurable from the beginning. That the prognosis is bad in a considerable proportion of cases of traumatic insanity must be conceded; but it is equally true that a certain limited number may be cured, or, at least, greatly improved by timely surgical interference. Obviously the cases which are most likely to be benefitted

by operative procedure are those of which the one reported is a type—that is, cases with depression of the skull, in which the location of the brain lesion can be determined with a reasonable degree of accuracy, the site of the lesion being such as to render the use of the trephine anatomically admissible.

By reason of the numerous and valuable contributions which have recently been made to our knowledge of neurophysiology and the localization of cerebral disease, the practice of trephining for the relief of epilepsy resulting from injury to the head has been revived, and it would seem to be not unreasonable to maintain that the arguments advanced in favor of the operation for epilepsy would apply with even greater force to cases of lunacy depending upon similar causes.

RUPTURE OF DIAPHRAGM.—Rupture of the diaphragm with escape of abdominal organs into the cavity of the chest is a rare accident, but when it does occur it is so uniformly fatal when treated on the expectant plan, that, in these days of heroic surgery, it would appear only reasonable to make an effort to save life by abdominal section, or by an opening into the chest. Either procedure would enable the surgeon to replace the dislocated organs and to close the rupture by suturing. A number of traumatic ruptures of the diaphragm with protrusion of abdominal organs into the cavity of the chest have been reported, in which during life, at least, a probable diagnosis could be made. All of the cases reported by Butlin and Brinton occurred on the left side. The physical signs on which the diagnosis was based consisted of tympanitic resonance over the left side of the chest which contained the prolapsed intestines, with diminution of vocal fremitus and respiratory sounds over an area corresponding to the displacement of the lung. In pneumothorax respiration is abdominal, in traumatic diaphragmatic hernia the respiratory movements are costal, and the abdomen is flattened; conditions which are suggestive of the escape of gas-containing intestine into the cavity of the chest.



Symptoms of intestinal obstruction indicate strangulation of the protruded bowel. Guttman regards displacement of the heart, in the absence of other causes, the most reliable diagnostic symptom.

An interesting case of traumatic diaphragmatic hernia which came into Albert's clinic has been described by von Horoch. The patient received a stab wound immediately under the left scapula. He died two days later with symptoms of asphyxia. The post mortem examination showed that the left lung and the diaphragm were punctured by the knife. Through the wound in the diaphragm a portion of the stomach which had also been opened, had escaped into the left pleural cavity. The reporter found three similar cases in literature. He suggested that in a diaphragmatic hernia, recent or old, presenting symptoms of strangulation, the chest should be opened sufficiently by rib section to permit reduction, and to close the wound in the diaphragm in such a manner that the sutures should embrace the serous coat of the stomach.

That the recognition of a diaphragmatic hernia is not always an easy task even after opening the abdominal cavity is illustrated by Ferrari's case. This surgeon performed laparotomy on a young woman who had suffered from symptoms of intestinal obstruction for seven days. The small intestines having been turned out from the abdominal cavity, a careful examination of their whole length, and of the cæcum, sigmoid flexure, and rectum was made without the discovery of any cause for the obstruction. The wound was closed and the patient rallied well and showed signs of improvement until next morning when sudden collapse manifested itself with speedy death. Post-mortem examination showed the existence of a diaphragmatic hernia from laceration—almost the entire transverse colon had escaped into the left pleural cavity, the distended loop of the intestine displacing the heart and left lung. In the space near the diaphragmatic ring it was noticed that the constriction of the bowel was such as hardly to admit the

tip of the finger. Upon trying to reduce the hernia, the ascending gut slipped back into the abdominal cavity without offering any resistance.

The establishment of a route to the diaphragm through the chest is not practicable on account of the frequency with which pleuritic adhesions are found and the greater amount of additional traumatism as compared with abdominal section, hence the latter should be preferred for the relief of diaphragmatic hernia in all cases in which a probable diagnosis can be made and in which symptoms of strangulation dictate the propriety and justifiability of the operation. If the injury is produced by a penetrating wound of the chest the method of operation suggested by von Horoch would be applicable and in case the symptoms pointed to visceral injury of the abdominal organs it should be combined with abdominal section.—*Dr. N. Senn, Address in Surgery.*

### Miscellany.

ANTIPYRIN IN PERNICIOUS FORMS OF MALARIAL FEVERS.—John Hope Potter writes to *The Lancet*, (April 10, 1886). "Whilst in charge of the Police Hospital of Bombay, during my tenure of office as Acting Police Surgeon I had considerable opportunities of testing the effects of different kinds of treatment in malarial fevers, of a remitting as well as of an intermitting type. In common with most men who have had much experience of these fevers, I met many cases of a remittent type which were not amenable to the ordinary treatment, whether by quinine, arsenic, or diaphoretics with aconite. I determined to try the effect in such cases of administering antipyrin in sufficiently large and repeated doses, to ensure a reduction of the temperature to the normal standard. The result was most satisfactory, so much so that during the last five months of my tenure of office I found no case that was not amenable to this treatment. Many cases that for weeks had been quite unaffected by the ordinary remedies were instantly cured by the exhibition of antipyrin followed

by quinine. The few cases in which I found the effects unsatisfactory eventually showed other complications, such as abscess of the liver or phthisis. I am of opinion that in pernicious forms of uncomplicated remittent fever we have a most valuable aid to treatment in antipyrin.

As I am not aware that this treatment has been advocated in the malarial fevers of the tropics, I write to give you the result of my experience, in the hope that it may prove of use to those who have to contend with this common and only too fatal disease."

**DRAINAGE OF IDIOPATHIC INTRACRANIAL ABSCESES.**—The evacuation of traumatic abscesses of the brain has long been a recognized procedure, and has met with a fair measure of success. Recently Mr. Hulke has endeavored to extend this practice to idiopathic abscesses within the cranium. A few months ago a man was admitted into the Middlesex Hospital, under Dr. Cayley, suffering from coma, which had supervened upon a long standing purulent discharge from the ear. There were no localizing symptoms. Mr. Hulke trephined the skull in the lower part of the temporal fossa, and by means of a director explored the temporo-sphenoidal lobe, without result. The operation was unattended with ill-results, but after the patient's death, a few days later, an abscess was found in the cerebellum. Quite recently a woman was under Dr. Cayley's care with similar history and symptoms and intracranial suppuration was diagnosed. Mr. Hulke determined to explore the brain. In this instance he made an aperture in the cerebellar fossa of the occipital bone, and through a small incision in the dura mater he passed a director through the cerebellum in all directions, but without striking an abscess. Finding that the symptoms were unrelieved, he subsequently trephined the temporal fossa, and opened an abscess in the temporo-sphenoidal lobe. We believe these cases will be duly reported to one of the medical societies. They mark an important advance in cerebral surgery, but further comments upon them must be

deferred until all the facts are before us.—*The Lancet*, April 10, 1886.

**THE TREATMENT OF MALARIAL FEVERS WITH TINCTURE OF IODINE.**—Mr. W. E. Hendricks states in the *Indian Medical Gazette*, December, 1885, that since the 15th of April last he has treated fifty cases of malarial fever with iodine. He believes that the iodine constitutes an efficient and cheap substitute for quinine. He has tried not only quinine but all the alkaloids, and arsenic as well, and in one or two cases he claims that more beneficial effects were derived from iodine than from quinine. Its use has been followed by no bad results. He was first induced to try the effects of iodine internally in a case of tertian ague with congested spleen of enormous size; with the thought that instead of applying the tincture externally, which after a period of sixteen years he had found almost useless, perhaps better results might be obtained by internal administration. For this purpose 5 minims each of the iodine and iron tinctures were given in an ounce of water twice daily, and after continuing this treatment for six days the fever that before then had come on regularly every day for three months quite disappeared, and the spleen began to diminish in size. The case remained under treatment for one month, up to which time the fever never returned, although the spleen still remained slightly enlarged. Of the fifty cases treated he states that there has been no return of fever as yet, though some of the cases were treated as long as six months ago: the average retention of the patient on the sick list so treated was only 4.3 days. In only one case had he to increase the dose of iodine from 5 to 10 minims, the former quantity not being sufficient to produce complete recovery, although the duration of the fever was cut short from three to six hours. Headaches, as the result of malaria, have also been successfully treated by this drug.—*Ther. Gaz.*

**SUTURES IN THE HEART.**—A paper of Block communicated to the Eleventh Congress of the German Surgical So-



ciety, 1883, on "Wounds of the Heart and their Cure by Sutures," having attracted the attention of Dr. Philippoff, he determined to make a series of experiments on dogs and rabbits for the purpose of satisfying himself of the truth of Block's assertion that sutures may, under certain circumstances, be applied to the walls of the heart. Though the Russian observer has not as yet concluded his investigations, he has published a preliminary note in the *Russkaya Meditsina* (No II) in which he states that the hearts of some animals will bear transfixion with a fine trocar or a needle, also that wounds of the heart in animals may be cured by means of sutures, but by no means always. He found, too, that the pericardium might be opened in dogs without any serious effects, but that wounds of the large vessels at their exit from the heart were invariably fatal.—*Lancet*, April 24, 1886.

**ANTIPYRINE.**—In paper on this subject (*Medical Record*, May 27, 1886,) the author, Dr. J. H. Frankenberg, of New York, arrives at the following conclusions:

1. We possess in antipyrine an antipyretic which will reduce temperature most powerfully and rapidly.

2. It is in the great majority of cases perfectly safe; only in very much depreciated states and in delicate children must it be warily given and guarded by cardiac stimulants.

3. It lacks nearly all the disagreeable features which other antipyretic drugs possess. Perspiration occurs in a large proportion of cases, but does not seem to enervate the patients or render them uncomfortable. Pruritus occasionally coexists with the eruption. Vomiting now and then occurs.

4. It may readily be introduced into the system through various channels. Its taste is not particularly disagreeable, and may be easily disguised by some aromatic. Hypodermically given it acts more decidedly and rapidly, and avoids the possibility of disturbing the stomach. It is unirritating. It may also be given per rectum,

5. It cannot cope with quinine as an antiperiodic or tonic, nor with salicylic acid in acute articular rheumatism.

6. It has practically no influence upon the pulse and respiration. If the pulse be dichrotic, the secondary wave entirely, or nearly, disappears. In other words, it raises the arterial tension.

**AN UNUSUAL CARDIAC LESION.**—M. Déjerine made a communication, on December 26, to the Biological Society of Paris, concerning an unusual cardiac lesion causing sudden death in two patients convalescent from typhoid fever. There were no cardiac symptoms during life. At the necropsy there was an absence of lesion, but examination with the microscope showed that the myocardium was broken up. Each fragment was constituted by an isolated muscular cell. There was neither fatty, nor putrid, nor pigmentary degeneration. In both cases the lesion of the myocardium consisted in a separation of the intercellular cement of Eberth, which in a normal condition unites the cells of the cardiac fibres. The phenomenon is observed in patients in an asystolic condition. It is due to the fact that the intercellular cement is dissolved by sarcolactic acid, which is formed in great abundance. There were no bacilli in the myocardium. Landouzy and Renaut have described this lesion in the myocardium subsequent to pericarditis.—*London Medical Record*, March 15, 1886.

**MAMMARY FUNCTIONS OF THE SKIN IN LYING-IN WOMEN.**—The breast may be regarded as a highly specialised sebaceous gland, or, at least, as a highly specialised cutaneous gland. It may have developed out of the indefinite blastema of the epiblast, either directly or through the intermediary stage of a sebaceous gland. The distinction made by Dr. Creighton at the discussion of Dr. Champneys' paper on Tuesday last, at the Royal Medical and Chirurgical Society, will, in view of deeper embryological considerations, appear to be of not great importance. For it is plain that the glandular structures to which he referred must have originated from

epiblastic germs, as the sebaceous sweat, and mammary glands have also done. That a sebaceous gland is also a miniature breast must be regarded as theoretically proven from a chemical standpoint. Milk is a chemical compound in certain proportions of albumen, fat, and sugar, and analysis of sebaceous matter also yields fat and a small proportion of proteid and carbohydrate. Dr. Champneys' most careful and detailed description of the "axillary lumps" forms the result of an equally sedulous research, which, so far as is known, is unprecedented, and therefore original in the true sense of the word. The lumps that he described as situated in the axilla may for all practical purposes be regarded as mammae. Their evolution follows step by step that of the mammary glands in puerient women, and there are some grounds for believing that they may be the seat of similar pathological affections. Further, Dr. John Williams bore testimony to the effect that, like the breast, the axillary lumps may show changes during menstruation.—*Lancet*, May 1, 1886.

### Medical Items.

M. Pasteur has just been appointed a Grand Cross of the Brazilian Order of the Rose.

The death is announced of Dr. Thaon, of Nice, well known for his work on Tuberculosis. He was forty years of age.

It is stated that the New York Academy of Medicine has received two bequests, one of \$70,000 and one of \$5,000.

Dr. F. Bessel Hagen has been appointed to the charge of the Surgical University Polyclinic in Heidelberg.

Why were the Newark children, who were inoculated against hydrophobia, like Nebuchadnezzar? Ans. Because they were sent to Pasteur.—*Med. Review*.

Prof. J. Edwin Michael has been elected Dean of the Faculty of the University of Maryland Medical Department, to succeed Prof. L. McLane Tiffany, resigned.

Important from Hot Springs.—A friend of ours went to the Springs for change and rest. The waiters got his change, and the hotels the rest.—*Med. Review*.

A recent law enacted in Georgia requires all preparations of morphine to be dispensed in scarlet paper with a scarlet label having the name of the contents in white letters.

The nineteenth annual meeting of the Canadian Medical Association will be held in the city of Quebec on Wednesday and Thursday, August 18th and 19th next.

For the vacant Chair of General Pathology in Insbruck the names of Dr. Gärtner, assistant to Professor Stricker in Vienna, and Dr. Lowit, assistant to Professor Knoll in Prague, have been proposed.

Professor Winter is about to retire from the editorship of *Schmidt's Jahrbücher*, with which he has been connected for thirty-six years. His place will be filled by Drs. Mobius and Dippe of Leipsic.

At the recent meeting of the German Congress of Internal Medicine, Dr. L. Weber, of New York, was admitted to membership in that distinguished body. It is the first time that this honor has been bestowed upon an American physician.—*Med. Record*.

The forty-first annual meeting of the Ohio State Medical Society will be held at Akron, Ohio, on June 2, 3, and 4, 1885, under the Presidency of Wm. Morrow Beach, M.D. Delegates and members should procure railway certificates from the Secretary, G. A. Collamore, M.D., of Toledo, before leaving home, specifying the route chosen.

The adulteration of lupulin with sand is largely practiced in England, according to J. S. Ward. In a paper read before the Liverpool Chemists' Association, he reports that the results of analysis of four samples obtained from houses of good repute justifies the belief that the lupulin of commerce will not answer the official tests. The percentages not soluble in ether were 55.24, 41.49, 40.64, and 39.41 respectively, and of ash 27.01, 29.10, 30.86, and 31.42 respectively.—*Med. and Surg. Rep.*

The Medical Department of the University of the city of New York, has just received a gift of \$100,000 for the construction and maintenance of a laboratory building, to be known as the Loomis Laboratory. The gentleman who has made the gift wishes that for the present his name should not be made public. Land adjoining the property of the College has already been purchased, and it is hoped that the new building will be ready for occupation next year.—*Med. News*.

Professor V. Frisch, of Vienna, who had recently returned from a visit to Paris, reported the results of his investigation into M. Pasteur's inoculation method to the Society of Physicians at Vienna. He said that M. Pasteur had unreservedly supplied him with every information, but owing to the prolonged period of incubation which often characterises hydrophobia, he held it to be premature at present to report definitely upon the utility of the practice. He also considered that the results should be controlled by experiments upon animals.—*Lancet*, May 1st.



Original Articles.

REMARKS UPON A SERIES OF  
CASES OF RÖTHELN (GER-  
MAN MEASLES) OCCUR-  
RING IN ONE FAMILY.

BY EUGENE F. CORDELL, M.D.,

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Medical College of Baltimore, and Attending  
Physician to Hospital of the Good Samaritan.

CASE I.—Boy, aged 10, had red eyes and lachrymation, and slight looseness of bowels, April 2d, 1886. Complained of sore throat on 3rd and 4th with sneezing, cough and headache. Took chlorate of potash, but did not stop school until 6th, when he came home with eyes and nose running, sneezing, cough and a papular eruption first noticed on the eyelid whence it extended to face, neck, body and extremities, being generally diffused over the surface by the 7th. The redness was more marked on the face than elsewhere. The face presented a mottled or blotched appearance, small papules being scattered freely over it. The papules were less numerous elsewhere, especially on the extremities. Each papule was the centre of a minute area of redness, but papules were also noticed on the arms and legs without any accompanying discoloration. The face presented a swollen appearance. He said the boy sitting next to him in school had had to go home on account of measles, although he had had the disease before. The catarrhal symptoms continued on the 8th, but the eruption was less marked. There was some complaint of soreness of throat and the entire surface of the pharynx, tonsils, soft palate and uvula presented a uniformly reddened and swollen appearance. The appetite was not notably affected and the spirits continued good. He was allowed to get up on the 8th, and this coincided, whether as coincidence or cause and effect, with fading of the eruption and apparent aggravation of the throat symptoms. On the 9th the eruption was gone. The throat continued congested. The glands in the neck

behind the sterno-mastoid muscle were enlarged and tender. The distal third of the tongue was red and raw looking, and covered with minute ulcers, which made the taking of food painful. Eyes less red. There is an occasional cough. The throat continued red to the 12th, with swelling of face and glands, and cough.

April 13th. Went out of the house for the first time. Had a loose passage.

14th. Was still a little hoarse..

16th. The lid of the left eye was swollen and red. There was no peeling.

CASE II.—Girl, æt. 5, sister of the preceding. Had cough and some hoarseness for about a week before April 21st. Cough especially annoying at night. On the evening of April 20th, a slight papular eruption was noted under the eyes, which on April 21st had spread over the face, arms and legs. Throat red and congested, but there is no complaint made of it. Post-cervical glands enlarged. Tongue normal. Chlorate of potash ordered. Coughed almost incessantly the following night, notwithstanding several doses of paregoric. Face swollen and red. Is slightly hoarse. Papules out freely on face, arms and legs. Appearance of eruption similar to that in case I. April 25th. Eruption fading but still visible on cheeks. Is still a little hoarse but has coughed but little last two nights. As the eruption passed away a tawny hue of the face was noticed. There was no desquamation.

CASE III.—Boy, æt. 3, brother of the two preceding. Sneezing and coughing noted for the first time April 25th, 1886, and eyes were red and swollen. These symptoms continued the 21st, and a papular eruption then appeared on the face. Cervical glands enlarged. Throat red and congested. Tongue normal and appetite good. April 22d, eruption nearly gone. Throat still red. April 23, eruption noted for the last time. Coughed much the night of the 24th, and was a little hoarse. April 25th tawny hue of face noted. There was no desquamation. Symptoms less marked and eruption less abundant than in cases I and II.

CASE IV. Mother of the preceding children, æt. 30. April 21st. Complained of aching in limbs and headache, and of eyes feeling as though sand were in them. April 22d. Papular eruption appeared, first, on face under eyes—spreading thence to neck, chest, arms, etc. Eruption not so distinct or abundant as in the children. Photophobia, slight itching, but no desquamation.

Thermometric observations were not made in any of the cases as the temperature of the surface did not appear to be much if at all elevated.

The cases above briefly related occurred in one household. The father of the children and a female servant, both over 40, did not contract the disease, unless a crop of small and painful ulcers upon his tongue were due to the epidemic influence.

These cases were undoubtedly Rötheln—the German Rubeola—which is now prevailing in this community epidemically, and for the following reasons: All four of those attacked and the two not attacked had had measles previously. The mother had it at 4 years of age, at which time her sister died from “suppressed” measles; the three children had it in the spring of 1883. The symptoms were very characteristically marked in the children and there could be no mistake in the diagnosis of measles. After a stage of invasion in the two elder children of 3-4 days—during which mild catarrhal symptoms were noted—a purplish-red sub-papular eruption appeared on upper part of face, spreading thence in the course of forty-eight hours over the rest of the body, with an increase of fever, with cough, sore throat, coryza, sneezing, suffusion of conjunctivæ, photophobia, hoarseness, anorexia, cervical adenopathy, emesis, diarrhœa, pruritus, furred tongue, eruption commencing to fade after three to six days and followed by free furfuraceous desquamation. A mild conjunctivitis was the only sequela. In the third child two and a-half months old—the symptoms were also well marked, but the attack, as is usual in very young infants, was comparatively mild.

The oldest of these three children had had scarlatina, the others had not had

it. The mother had also had it in childhood.

These facts conclusively exclude the idea of the affection being measles, for whilst second attacks of measles may occur, they are yet extremely rare, quite as much so, according to the authorities, as second attacks of scarlet fever and small-pox. It is also altogether improbable that there would occur four second attacks of measles simultaneously in the same family, and that the protective influence exercised by so recent an occurrence of the disease would have been lost in all of the children.

The diagnosis may therefore be considered established, as there is no other disease with which the above description corresponds.

It remains therefore to note the points of difference or resemblance which these cases bear to measles, and we may for comparison take the two attacks of 1883 and 1886. Comparing cases I and II of 1884, we find stage of incubation apparently of eleven days. Making the same comparison in the recent attack and we find a period of incubation of about fourteen days. The stage of invasion in measles was three to four days; in rötheln it was four to five days.\* The symptoms of the stage of invasion present no differences in the two series being in both characterized by mild catarrhal symptoms. The character of the eruption presented some slight differences. It appeared in both first above or below the eyes or on the lids. It was more distinctly papular in rötheln. The crescentic arrangement of the spots so characteristic in measles was absent or not noted in rötheln. The spread of the eruption over the surface was more rapid in the latter. The color of the eruption was of a lighter shade of red than in measles, but paler than the scarlet hue of scarlatina. The description—pale-rose—usually applied to it, characterizes it fairly well. The face, which was more deeply discolored than the rest of the body presented a suffused appear-

\*This is the reverse of the usual observation, which is that the period of invasion is much shorter in rötheln, being from a few hours to one or two days as a rule.



ance—a glow as it were—but the redness was not uniform but in patches, the papules presenting a deeper hue than the surrounding reddish areas. There was no itching at all in the children, and it was but slightly marked in the adult; whereas in most cases of measles it is very annoying and often intense. The eruption disappeared much sooner in rōtheln than in measles, lasting three to six days in the former, whereas it was visible for two to three weeks in the latter. There was no desquamation in rōtheln. The tongue was not furred nor were the appetite and taste lost or perverted as they very conspicuously are in measles. The uniform and more extensive redness of the throat in rōtheln has possibly some diagnostic significance.

The points of resemblance to measles are therefore many whilst the points of difference are not very striking. The two diseases, as exemplified in these attacks differ chiefly in degree and in the presence or absence of itching and desquamation. The hot skin of measles contrasts strongly with the absence of appreciable rise of temperature in rōtheln. The latter presents the appearance of a mild measles. It might be suspected but the diagnosis could hardly be satisfactorily made out in the absence of a knowledge of the prevalence of the disease in the neighborhood or community and where the patient had not previously had measles. The resemblance being so great to measles, the diagnosis will chiefly depend upon the exclusion of that disease, and yet it has been mistaken for scarlatina, a mistake which might be pardonable if the throat symptoms were prominent, if there were rather high fever, and if the papular character of the eruption were but ill marked. A physician of well known diagnostic accuracy told me recently that he had had cases of a mild eruptive fever which had been diagnosed as scarlet fever by other physicians of experience, and which he had not been able to satisfy himself as to the nature of. I have little doubt that these were cases of rōtheln. Professor Louis Thomas, of Leipzig, the author of

the article on this affection in *Ziems-sen's Cyclopædia* makes the following statement: According to my observations the exanthem of rubeola possesses a similarity to that of measles only, not the slightest to that of a normal scarlet fever.

It is a fact worth noting that there is a wide-spread epidemic of true measles now prevailing in the city, and that cases of scarlatina are also numerous.

Table showing mortality from measles and scarlatina in Baltimore.

1885.	Measles.	Scarlatina.
January.	1	11
February.	0	6
March.	0	8
April.	1	9
May.	0	9
June.	1	6
July.	5	5
August.	3	6
September.	1	1
October.	0	0
November.	3	3
December.	1	4
1886.		
January.	5	5
February.	7	2
March.	19	3
April.	52	3
May (to 15th)	23	2

This table hardly represents correctly the mortality of the disease, because many deaths referable to it are, without doubt, classified under other heads, as pneumonia, bronchitis, phthisis, etc.

There were no deaths from Rōtheln during the above period, but I learn from inquiry at the Health Department that such deaths if they occurred would be included under the head of "measles."

That Rōtheln is a distinct affection—communicable—infectious—epidemic—there is no longer any doubt since the memorable discussion before the International Medical Congress of '81. The disease has been recognized for many years, more than a century in fact in Germany, and for several years in this country. Some claim to have met with a large number of cases in this city; the above, however, are the first cases that I have seen to recognize, and as the diagnosis is so clear, they seem to me to

be of considerable interest. I may add that Rötheln does not always present the well marked features of the cases which I have reported. Considerable variability is noted by different observers in the clinical manifestations of the disease,\* and this absence of uniformity has caused some confusion, not only in its descriptions but also in the conceptions of its nature. Some have even imagined it to be a hybrid between scarlatina and measles, both of which it resembles, whilst others have confounded it with roseola. Nor is it always the mild and harmless affection here pictured; whilst usually justifying a highly favorable prognosis, some epidemics have presented grave features, and one of the speakers at the International Congress referred to three cases under his observation requiring tracheotomy.†

The only one of the cases above reported in which anything like a sequel occurred was the youngest child, æt. 3. The eruption was observed last on the 23rd; but slight hoarseness, cough, and a tawny hue of skin are noted on the 25th. On the afternoon of the 25th, after a long walk, he was found to have a hot skin and high fever, which was succeeded that night by a free perspiration. On the 26th the fever had remitted. There was anorexia. Four grains of quinine were given. At noon the fever appeared to rise again. The nose now bled to a slight extent, and he complained of pain in the back. Repeated the quinine at night, and again the next morning. The bowels, which were rather loose from the beginning, were especially so on the 27th., the discharges being copious, thin, yellowish, offensive and very frequent. The fever continued with morning remissions and evening exacerbations. A frequent and harassing cough accompanied, and abundant moist and dry bronchial râles were audible over both lungs. Drowsiness was noted, especially in the evenings. Pain in temples was complained of on the 27th, and there was also sick stomach. The pulse varied

from 130 to 150, and respiration from 40 to 50. On the 28th there were six passages. Tympanites was also noted. By May 2, the diarrhœa was entirely gone, and there was some appetite, but the cough continued for a week longer.

My diagnosis of this case was typhoid fever, and the ensemble of symptoms—copious diarrhœa, yellowish watery operations, epistaxis, continued fever, tympanites, acute bronchitis, headache, serious illness of the child, and the failure of the quinine to arrest the attack, appear to me to place the diagnosis beyond question. That the symptoms were not referable to the bronchitis is shown by the fact, that this occurred secondarily to the fever, and also by the remissions and the diarrhœa. The bronchitis, was, however, quite intense.

*Addendum.*—An analysis of the descriptions of various authors who have seen epidemics of this disease reveals a great want of uniformity, and frequently an absolute contradiction of statement, showing conclusively the need of further and more accurate study of it. It may ultimately be found that two distinct affections are included in these descriptions. The stage of incubation is said to be 17 to 21 days, 6 to 21 days, and 11 to 12 days. The stage of invasion is said to last a few hours,  $\frac{1}{2}$  to 1 day, an average of 3 days, to 7 days as the maximum. The stage of eruption is described as lasting 2 to 4 days, 2 to 15, 3 to 5, and 4 to 10 days. The writers consulted all agree as to the presence of catarrhal symptoms—cough, sneezing, hoarseness, sore throat, congestion of conjunctivæ, pharynx and soft palate, furred tongue, enlarged cervical glands, and communicability. Photophobia and lachrymation are by some asserted to be present, by others absent; and so of albuminuria, desquamation, and fever, the temperature sometimes reaching 104°. A characteristic odor is mentioned by one writer only. Itching is “rarely” noted, and by none as excessive. Yellow or brown pigmentation is noted by several, whilst others are silent regarding this symptom. The color of the spots is described as “rose,” “pale-rose,” and “red,” the character of

\*See addendum to this paper.

†See also epidemic reported by W. A. Edwards, M.D., in *Amer. Jour. Med. Sci.*, October, 1884.



the eruption as macular and papular; the shape of the spots as "round or oval," "roundish," "not circular;" the eruption becomes general in  $\frac{1}{2}$  day to 2 days; the part or parts first affected are the "head," the "face," the "face and head" (this most frequently), the "face and chest," the "back and chest." The description given in Roberts' *Practice* corresponds almost exactly to the cases above reported, whilst that in Flint is very inaccurate and unreliable, but Flint had evidently never seen a case of the disease. Bartholow confounds Roseola and Rötheln (ed. of 1882).

I heard of a homœopathic physician who diagnosticated an affection in one of his little patients as "pink-eye;" was this not probably rötheln?

### PUERPERAL ECLAMPSIA.\*

BY WILMER BRINTON, M.D., OF BALTIMORE.

*Mr. President and Gentlemen:*

Through the kindness of the Chairman of the Committee on Lectures, I have the privilege of reading a paper on "*Puerperal Eclampsia, with the Relation of some Cases of the Same, Met With in Practice.*" In the beginning, I hasten to assure you I have no new theory as to the causation of the disease in question. But in order to understand the *rationale* of the treatment carried out in the cases which I shall later on relate, and which I believe to be the best in the larger number of cases of puerperal eclampsia, it will be well for us to inquire into the condition existing at the time of the convulsions, and what the now accepted facts are concerning the causation of this dreaded and alarming complication in what our Creator destined should be a physiological act.

As early as 1851, Frerichs, Braun, Wieger, and others, pointed out clearly the close resemblance between the convulsions occurring in pregnancy and the uræmic convulsions of Bright's disease, and though from that time until the present, this fact has been attacked on

all sides, the evidence which has accumulated from medical men's experience during the intervening (35) years has resulted in placing this fact upon an almost impregnable basis. Now, let us for a moment review some of the objections that have at different times been urged against the so-called "Uræmic Theory," that we may better understand the position of the question as it now is.

1st. It has been claimed by a number of authorities that convulsions may occur without albuminuria.

2ndly. That the albuminuria is in many cases the effect, and not the cause, of the convulsions.

3rdly. That in many fatal cases the kidney lesions were absent, or wholly insignificant.

4thly. Convulsions are rare in chronic Bright's disease which had existed prior to pregnancy.

As Lusk, of New York, very truly says:

"That in the main, these propositions are correct, hardly admits of question, but in drawing conclusions from these, unnecessary stress is laid upon the presence or absence of albumen in the urinary secretion. It is the renal insufficiency. It should be fixed in the mind, and not the albuminuria, which causes uræmia and convulsions."

The mere absence of albumen from the urine does not even exclude the existence of "Bright's disease."

Carl Braun, of Vienna, has proved conclusively by post-mortem examinations, that amyloid degeneration of the kidneys and heart existed in cases of fatal puerperal eclampsia, when at no time was albumen found. Baily, and others, have also shown that not rarely albuminuria in pregnant women may disappear for several hours, and then reappear, so that it is possible for an examination to be made during the short period when the urine ceases to be albuminous.

On the other hand, chronic disease of the kidneys does not necessarily imply insufficiency of the renal secretion; for in practice how often do we see patients with undoubted evidence of chronic

\*Read before the Clinical Society of Maryland, at Stated Meeting, held April 16th, 1886.

nephritis enjoying a fair share of health, showing conclusively there is no marked insufficiency of the renal secretion? Nephritis, chronic in character, existing before pregnancy, brings with pregnancy great danger to the patient. Hofmeier, of Berlin, observed 46 cases of chronic nephritis when pregnancy occurred. Only one-third of the 46 had eclampsia, but one-half of this number died.

Including acute and chronic cases together, Braun estimates that only 60 in the 100 develop uræmic convulsions. Prof. Bamberger, of Vienna, reports from autopsies in the general hospital there, that in 12 years there were 2,430 cases of Bright's disease *post mortem*, of which 152 were found in puerperal and pregnant women, and only 23 of the 152 cases had puerperal eclampsia. The objection to the uræmic theory, owing to the lack of a pathological condition of the kidney observed in *post mortem* examinations, loses most of its force, when we remember that in a large proportion of cases the retention of excrementitious material is due to acute suppression. Thus, in 104 cases of puerperal eclampsia reported by Hofmeier, of Berlin, the kidney symptoms developed suddenly. Spiegelberg argues that the sudden suppression of the urinary secretion can only result from disturbance in the renal circulation, claiming that a rapidly developed affection of the vessels would leave no marked *post mortem* trace, and would, in case of recovery, disappear as quickly as it had come. If the kidney trouble were due, as was formerly supposed, to pressure of the gravid uterus upon the renal veins, the kidneys, in *post mortem* examinations would exhibit evidence of congestion, whereas, usually, they are found to be pale and anæmic. Of course the precise nature of the change in the circulation is not definitely known. Spiegelberg suggests that either the walls of the vessels are altered in such a manner as to interfere with the process of diffusion, or that a reflex contraction of the vessels due to a peripheral stimulus, operates to cut off the blood supplies to the kidneys. Franken, however, having demonstrated a direct connection

by means of the sympathetic nerve between the ganglia of the kidneys and the nerve filaments of the uterus likewise suggested that the albuminuria of pregnancy was due, not to pressure, but to the excitation of the uterine and renal nerve plexuses. After bringing these facts and statistics to your notice, we shall now direct your attention to the causes of the outbreak of the convulsions. As it has been conclusively shown that not every case of nephritis, or even of kidney insufficiency, is followed by eclampsia, though convulsive attacks are much more common in the uræmia of pregnant women, Frerichs believed a ferment in the blood converted the urea into carbonate of ammonia, but Spiegelberg, by later investigations, proved this theory to be incorrect in the main, and declared ammoniæmia to be one of the rarest causes of convulsion. Then, later on, we had given to the medical world what is known as the Traube and Rosenstein theory. This theory held that eclampsia took place when, in persons rendered hydræmic by the loss of albumen, the aortic pressure was suddenly increased, the increased pressure giving rise successively to œdema of the brain, then to secondary compression of the vessels, and, finally, to acute anæmia. An anæmic condition of the hemispheres would, it was predicted, produce coma, while convulsions would ensue if the condition extended to the motor centres. But *post mortem* examinations have not proved this theory. Löhbein, in 19 *post mortem* examinations, found but one case of œdema, anæmia, and flattening of the convolutions. Lusk, Spiegelberg, and others, in their latest publications on the subject, do not accept the theory of Traube and Rosenstein. The disposition to ascribe convulsions to central anæmia is based upon the experiments of Tenner and others, who demonstrated that convulsive twitchings might be produced in animals by tying the carotids, or by opening the large vessels of the neck and allowing them to bleed to death. It is, of course, anticipated that anæmia due to systole of the arterioles would be followed by the same results. The pheno-



mena of convulsions are two-fold, viz., loss of consciousness, and tonic and clonic contractions. Loss of consciousness is easily to be accounted for by the anæmia of the hemispheres, precisely as in cases of ordinary syncope. Convulsions occur, however, when the brain is removed, if only the pons varolii and the medulla oblongata are preserved. Deiters has shown that the motor fibers of the extremities and the trunk have their first central terminations in the pons. Nothnagel has proved that a collection of ganglionic cells in the substance of the pons furnishes the motor center from which the convulsive impetus takes its departure. According to other authorities, the groups of gray matter for the cranial nerves are situated in the floor of the fourth ventricle, and in the substance of the medulla oblongata, any influence, therefore, producing contractions of the arterioles through the vaso-motor nerves would necessarily produce both coma and convulsions. As, however, convulsions may take place without loss of consciousness, Nothnagel concludes that the same causes which act indirectly through the vaso-motor nerves may simultaneously set in action the centers of muscular movement. Therefore, Mr. Chairman and gentlemen, it is rational, I believe, to divide the causes of puerperal eclampsia into two great classes: Those due to centric causes, and those proceeding from peripheral irritation. But I believe, from personal experience, and from my reading on the subject, that the vast majority of the cases are due to centric, and in these cases uræmia is the fountain head of the evil. "The term uræmia," as Lusk very nicely puts it, "signifying of course the action, not of a single constituent of the urine, but of all the excrementitious principles, combined with that of increased arterial tension." In cases of eclampsia due to uræmia, the greater portion develop during labor. Thus, in Löhlein's collection (a hundred and sixty in number) 93 of the cases occurred while the patient was in the parturient act. Now, if we accept the fact that the larger number of cases of puerperal eclampsia is due to a defective elimination of urea, what is the

best treatment for a given number of cases of the disease in question? I am old-fashioned enough (if you please to term it so) to believe that medical men of the present day do not bleed enough, and I believe, everything being equal, the medical man who uses his lancet in a discriminating manner in puerperal eclampsia will save more of his patients than another who has not the courage and nerve to brave the popular prejudice against blood-letting, and treats his patient with hypodermic injections of morphia, chloroform, kalii bromide and chloral. Spiegelberg claims that blood-letting, in case of uræmia, will lower arterial tension, diminish to the fullest extent practicable the irritation of the vaso-motor and convulsion centers, and restore to the kidneys their normal action better and more completely than any other agent.

In support of this view, I have the pleasure of reporting some cases occurring in practice.

CASE I.—I was called about 2 P. M., November 9th, 1876, to see Mrs. H., living on Harford Avenue, near Monument Street. I found she was in labor, and just recovering from a convulsion as I entered the room. From the midwife who had charge of the case I obtained the following history. Mrs. H., the patient, age 26, born in Baltimore, married 14 months previous; had good health until one month preceding the time of labor. During that time she had so much swelling of the limbs that she could not attend to her usual domestic duties, and was obliged to remain either in bed or in a sitting posture most of the time. She passed only a small amount of urine, was constipated, had sick stomach and headache, and was saying to everyone that "she knew she would die." The patient had sent for the midwife several times during the month, believing herself to be in labor, but they proved to be false alarms. On each of these visits, the midwife informed me, she tried to persuade Mrs. H. to employ a physician, but always in vain. The midwife was called again at 8 A. M. of the day I first saw the patient and found her in labor. But slow

progress was made, yet the patient seemed to the midwife to be doing fairly until just beyond 2 o'clock in the afternoon, when, at the end of a rather severe pain, she had a convulsion. So soon as this occurred doctors were sent for, and I was the first to arrive. As I entered the room the patient was just recovering from her second convulsion. Dr. John Stevenson, then of Exeter Street, since deceased, came in a minute or two later, and we took charge of the case together. While we were talking to the patient, she had her third convulsion. Dr. S. gave her chloroform at once, and when fully under its influence, I examined her and found, although she had been in labor some seven hours, very little progress had been made. The "os" not much dilated. The cervix rigid, hard and undilatable, the parts hot and dry, the vertex presenting, the child being in the first position, and its heart sounds faint and weak. Kalii bromide grs. xxx hydrate of chloral grs. xx were given the patient *per rectum*, which was continued every two hours. Inhalation of chloroform during the convulsion. This plan of treatment was continued with addition of two hypodermics of  $\frac{1}{2}$  of a grain of morphia until 10 o'clock at night, but the convulsions, while decreased in frequency, seemed more severe in character. At this hour, upon examination, the foetal heart sounds could not be heard and upon examination per vaginam, the os was found still undilated, and as our patient had been in labor some fourteen hours, Dr. Stevenson and myself determined to bleed her, which I did from one of the veins of the arm to the amount of twelve or fourteen ounces. After the bleeding the pains were more frequent and more powerful and at 11.30, the first stage of labor being nearly completed, I applied Hodges' forceps and without much traction delivered a dead male child. During the delivery of the placenta, about thirty minutes after the birth of child, the patient had a very slight convulsion, immediately followed by a very decided post-partum hæmorrhage, but with hypodermic injections of ergot and compression of the uterus by

two fingers of hand in vagina and the other hand on the abdominal walls, the hæmorrhage was soon controlled. From this time on our patient did well. The œdema about the vulva and limbs soon disappeared and on her tenth day she got up out of bed and in a fortnight resumed, to some extent, her usual domestic duties. I have since attended this woman in three confinements which were perfectly normal.

CASE II.—10 o'clock A.M., December 23d, 1878 I was called for the first time to see Mrs. B., living on Eden Street near Gay; found her in convulsions, with the *history* of being pregnant for the first time, and looking for her confinement some time in January, 1879. I administered chloroform and upon examination per vaginam I found no evidence of beginning labor. From this time until late in the evening, in spite of chloroform, morphia hypodermically, and free purgation, my patient continued to have convulsions. Dr. John J. Gross, of this city, then saw the patient with me and we continued the same line of treatment with the exception of larger doses of chloral and bromide by the bowel, which for (ten) hours kept our patient at rest; 4 o'clock on the morning of December 24, I was called again to our patient Mrs. B., and found her having convulsions of the most alarming character; her tongue having been bitten, was bleeding and very much swollen. I gave her chloroform and when she was fully under its influence, I bled her freely from her arm, and continued on with hydrate of chloral and bromide of potash by the rectum. At 10 o'clock A. M., she had a slight convulsion, and from this time they returned no more. She remained under my care until her confinement, January 17th, 1879—or about twenty-four days from the time of her first convulsion. My treatment during this time was milk diet, laxative medication, Buffalo lithia water, ad libitum and kalii bromidi grs. xx on going to bed. She was in labor some eighteen hours, and was delivered with Hodges' forceps of a living female child and had a perfectly natural lying-in period. I would say I examined this



patient's urine several times during my attention to her and always found a decided amount of albumen, while the specific gravity varied from 1010 to 1027.

CASE III.—8 o'clock Thursday night October 11th, 1879, I received a hurried message to visit Mrs. K., 443 N. Gay Street. Upon responding promptly I saw Mrs. K. for the first time, and found her to be a young German woman in her first labor; she had been in charge of a midwife and had been in labor all day and had done well until a few minutes before I saw her, when her first convulsion occurred. Upon chloroforming her and making a thorough examination I found the first stage of labor completed, child presenting vertex, L. A. O. I. position, foetal heart heard to the mother's left distinct and strong. Sending for assistance and my forceps I continued to use chloroform during the convulsions which followed one another in rapid succession. My friend Dr. Geo. A. Hartman soon responded and continued the chloroform while I applied Hodges' forceps, and after considerable traction I delivered a living female child. The after birth was removed in a few minutes later and I now thought all of my patient's trouble would soon cease, but in spite of delivery, hypodermic injections of morphia, kalii bromide and chloral by the mouth, and chloroform during the convulsion, my patient had several severe convulsions during the night. At 8 o'clock next morning she had a convulsion more severe in character than any she had had. This determined me to bleed, although I hesitated on account of her pulse which was weak and rapid, being 125. I opened the vein of her arm and took blood to the amount of a pint. From this time on my patient had no more convulsions, but the bromide and chloral were continued at intervals for some days. It was fully a month before my patient was able to get around, although she did perfectly well during her lying-in period. I have since attended the same lady in two other confinements, which were perfectly normal.

CASE IV.—I was engaged in August,

1884, to attend Mrs. S., of No. 401 E. Eager Street, in her first confinement about December 1st, 1884. On the 20th of October, I was sent for to see Mrs. S. by her aunt, who was also to be her nurse, a woman of large experience and some intelligence. I was informed by this lady that her niece Mrs. S. was not doing well and she was fearful of her having trouble, that she had a very sick stomach, was passing a very small amount of urine, her limbs and privates were badly swollen, but the most prominent symptom for which I had been summoned was a feeling of pressure about the top of the head, the patient herself comparing it to a heavy weight pressing her down. She also complained of vertigo at times. Upon examining her urine that night I found the specific gravity to be 1028, and a decided trace of albumen. Upon a microscopical examination by a medical friend, whom I consider a competent microscopist, he reported no casts, but a very decided increase in the epithelium. Upon my taking charge of Mrs. S.'s case I placed her at once upon a decided treatment, giving her iron and infusion of digitalis through the day and grs. xx of kalii bromide on going to bed, Buffalo lithia and natural water *ad libitum*, milk diet, as much rest as possible, and from time to time an occasional purge of podophyllin, comp. ext. colocynth, jalap etc., etc. Under this treatment my patient became more comfortable, her sick stomach improved, she slept better, passed more urine, her bad feeling about the head passed away to some extent and while the oedema about the vulva and limbs was better, yet did not pass away enough to make my patient comfortable in locomotion. Repeated examination of the urine always gave the same results, viz: specific gravity 1028 to 1030, and always decided evidence of albumen by the heat and nitric acid test.

November 24th, 1884, at 8 o'clock A. M., I received a hurried message to visit Mrs. S., and I obeyed with some trepidation expecting to find her in convulsions, but found her in labor, with history of beginning pains about 4 o'clock in the

morning or some five hours previous to the time I first saw her; upon examining I found she was quite well advanced in the first stage of labor, the cervix being dilated and dilatable, the child presenting vertex, L. A. O. I. position, the foetal heart sounds being heard clearly and distinctly to the mother's left. During the balance of the day she had normal labor pains and was delivered naturally of a living male child at 7 P. M., after being in labor fifteen hours. I expelled the placenta by Credé's method ten minutes after birth of the child. And after remaining an hour (my usual custom) and seeing my patient was made clean and comfortable, uterus well contracted, pulse and temperature normal, I left her a few minutes past 8 o'clock P. M. As far as I could see she was doing well. At 9.45 P. M. I received a message from druggist in the vicinity of my patient's residence, informing me that my patient Mrs. S. was having a convulsion and her husband was in the store awaiting to hear from me. I prescribed by telephone a mixture containing bromide kalii and chloral hydrate, with instructions to give the patient a tablespoonful at once, each tablespoonful containing twenty grs. of bromide of potash, and fifteen grs. of hydrate of chloral. In twenty minutes from this time I was by the side of my patient, found she had recovered from her convulsion and had taken one dose of her medicine. A few minutes after my arrival she had a second convulsion, severe in character, but was easily controlled by inhalation of chloroform. I remained at my patient's house all night, during which time the bromide and chloral was continued every two or three hours, but my patient never had more than the two convulsions, and afterwards did fairly well. The œdema from the vulva and limbs disappeared in a few days, and although iron and other tonics were given, it was some time before Mrs. S. regained her strength, and lost entirely what she termed "the peculiar feeling about the head."

*Mr. Chairman and Gentlemen:*

The relation of the last case is somewhat foreign to the object of the paper,

but I have related it for two reasons; one to show how important it is to give special prophylactic treatment to pregnant woman presenting the symptoms this patient did. The other to prove that in the treatment of puerperal eclampsia, I am not a hobbieist in the use of the lancet.

### ASEPSIS NOT ANTISEPSIS. A PLEA FOR PRINCIPLES, NOT PARAPHERNALIA IN LAPAROTOMY.\*

BY HOWARD A. KELLY, M.D., OF PHILA.

Medicine, like other branches of science, has been most retarded in its growth by the accumulation of all sorts of useless details. Some of these incrustations still clog the advance of abdominal surgery and will be given up with a notable diminution in the general percentage of mortality. I refer to the use of carbolic acid and mercuric solutions at the operating table and to the continued use of any elaborate abdominal dressing.

The use of antiseptics in the patients belly is full of danger and inconsistencies for the following reasons.

*Firstly:* If used in strength sufficient to certainly prevent sepsis, the patient is very often killed along with the germs. I have myself seen death from carbolic acid poisoning. *The American Practitioner*, November, 1881, p. 260 quoted by Dr. Goodell, "The first four cases done in the theatre at the beginning of last season had hæmorrhage from the kidneys and two of them died. I never had anything like that before. It was purely carbolic acid poisoning, of that I have no doubt whatever." Thos. Keith speaks of several cases in his own practice, and references might be indefinitely multiplied. Regarding the use of the bichloride solution, it is sufficient to say that its use has been very much curtailed in all maternity hospitals even as a vaginal wash. The danger line is here a very broad one for the limit

\*Read before the Obstetrical Society of Philadelphia, May 6, 1886.



appears only to depend upon the most variable of all factors, the individual susceptibility.

*Secondly:* It is the great tendency of all operators, and in particular their assistants, to forget the principle involved, and pin their faith to the accidental means of establishing it. This can be seen abundantly illustrated in almost any hospital in the land, where a clean napkin worked in and around the joints and grooves of the instruments in use, or carried under the nails of the operators fingers, will exhibit sad evidences of soil. Then too the actual conduct of the operator is often modified by the false sense of security begotten by the incomplete use of antiseptics. I saw this well illustrated by a surgeon of more than local repute. The case was a herniotomy in which a large femoral sac was opened. The spray was throwing out a dense cloud, instruments and sponges were immersed in a two per cent. solution of carbolic acid and elaborate dressings were ready. A coil of intestines protruded from the wound for several inches and it lay, first, on the old hospital blanket below and then in the effort to reach the ring was turned upon the night gown above. The antiseptics was here made a farce by these and other glaring inconsistencies.

If germicides must be used at all, let it be before the operation and in strength sufficient to neutralize any sepsis about instruments, sponges, etc. Then let the operator go to work with clean instruments, clean sponges and clean hands and he will need no antiseptic and the patient's belly will no longer be a battle field where germs and solutions fight, often with such direful results to the host. It is my belief that it will not be long before the day of solutions will be past, and that in the future the successful surgeon will go to his work with pure water or dry pans for his instruments and fluid enough to cleanse sponges. My own practice has been to use hydrant water boiled for an hour and allowed to stand, or better still, distilled water, as used by Prof. Schroeder and independently suggested and used by my friend Dr. Jos. Price. I do not believe

that reservoir water, dirty as it often is, ever contains any of the specific matter productive of septicemia; but the process of boiling and using only the supernatant liquid makes it perfectly harmless.

Another fallacy discarded by some of the greatest operators, but perpetuated by many is the transference of the use of the elaborate Listerian dressings of general surgery to the abdominal wound. These dressings, so manifold and multi-form are clearly intended to prevent sepsis from penetrating the now closed abdominal wound. This is an accident which fortunately never occurs in the intra-peritoneal method. The rapid agglutination of peritoneal surfaces affectively closing the sac, a sterile dry powder will absorb the slight serous discharge at the edge of the wound and suture exits, and above this some absorbent cotton and a firm bandage is all that is required.

While the danger of infection of the peritoneum through the closed wound is minimal; that of an infection of the belly wall through stitch holes is very great, and this is best prevented by the dressing recommended by Keith of carbolic acid and glycerine one to eight parts.

With the mind thus freed from the notion that these solutions and dressings are accomplishing nothing—from two such dangerous fallacies—operators at large will then work with a living consciousness of the real conditions of success, and they will then be on the alert from the beginning of the operation to its close, keeping within the mental horizon an exact knowledge of everything coming in contact with the patient's belly.

The expression of my convictions and practice will be of value in so far as they are in accord with the following letters upon the subject by the two greatest abdominal surgeons in the world, Lawson Tait and Thomas Keith. Lawson Tait, in a letter, dated March 15, 1886, to the writer says: "I still use tap water and nothing else; it is never boiled; my instruments are prepared by being washed in soap and water merely.

I use no elaborate dressings for the wound, never using anything at all except absorbent cotton wool."

Yours Very Truly,

LAWSON TAIT.

From a communication from Thomas Keith, of Edinburgh, written March 16, 1886. I make the following extract: "The secret in abdominal surgery, the secret in all surgery, consists in carrying out the antiseptic principle. You may do this in a simple way or you may do it in a complicated way. All instruments, needles, forceps, sponges, etc., everything about the wound must be disinfected. A weak carbolic solution applied to the wound can do no good—nor harm. You may safely use hot water. My instruments, after an operation, are scrubbed with a nail brush, especially the forceps points. This is repeated before the next operation with a 5 per cent. solution of carbolic acid. The greatest risk is that we put in septic matter on our hands, instruments and sponges. Sepsis may come from the wound, but it rarely ever penetrates inside. I use a simple dressing of gauze, eight or ten folds soaked in one to eight carbolic acid and glycerine extending to two or three inches beyond the line of incision on all sides. Over this some ordinary cotton wool, a flannel bandage and nothing else. Use this and you will never use anything else, and don't look at it for a week or ten days. You ought for the patient's comfort to put on an antiseptic dressing of some kind. You will probably often have suppuration with stitches if you do not."

Your Sincerely,

THOMAS KEITH.

The *salicylate of lithine*, in fifteen to forty grain doses, repeated several times in the twenty-four hours, has been found especially beneficial in acute rheumatism, where the *fibrous tissues* are chiefly attacked. It is best to use it after meals.—*Progres Medical*, No. 7 1886,

## Society Reports.

### THE CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 16, 1886.

The President, Dr. L. McLANE TIFFANY, in the chair.

*Dr. Wm. A. Moale* presented a girl upon whom he had done a supra-condyloid osteotomy and to whom he referred in reporting the case at the meeting held February 19th, 1886. To all practical purposes the result is perfect.

*Dr. Wilmer Brinton* then read a paper on

PUERPERAL ECLAMPSIA.\*

#### DISCUSSION.

*Dr. John Morris* had never seen puerperal eclampsia in a multipara always in a primipara. Thought this singular; congratulates Dr. Brinton on the success of his treatment.

*Dr. Wm. H. Norris* thought if the old fashioned plan of bleeding was more frequently resorted to in these cases our results in many instances would be better.

*Dr. W. W. Winsey*, contrary to Dr. Morris' experience had seen a fatal case of eclampsia occurring in the fourth labor.

*Dr. G. H. Rohé* thought nothing definite could be said as to the value of the different lines of treatment in this trouble until we had recourse to a carefully compiled statistical report.

*Dr. John Morris* recently had a patient with Bright's disease who became pregnant and died with all the symptoms of eclampsia except convulsions.

*Dr. Wilmer Brinton's* experience as to the occurrence of eclampsia in primiparæ coincides with that of Dr. Morris. He had three cases in his practice in one year.

*Dr. S. T. Earle* has seen four cases, two occurring in primiparæ and two in multiparæ. The lancet was used with the happiest result.

(To be continued.)

\*See page 105.



## OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, HELD MAY 6, 1886.

The President, B. F. BEAR, M.D., in the chair.

*Dr. Howard A. Kelly* read a paper on

ASEPSIS NOT ANTISEPSIS. A PLEA OF PRINCIPLES, NOT PARAPHERNALIA IN LAPAROTOMY.\*

## DISCUSSION.

*Dr. Montgomery* feels great interest in *Dr. Kelly's* remarks, reinforced as they are by the letters from Tait and Keith. The antiseptic method of treatment has done a great work for surgery, and the successive steps of Listerism and cleanliness have brought it up to the comparative certainty of result now attainable. We can now eliminate almost entirely the antiseptic agents carbolic acid, mercuric chloride, thymol, etc., and can do as well by the most rigid attention to cleanliness in all details of hands, instruments, sponges and the skin of the patient. Some years ago he felt gratified that, in a patient upon whom he operated before a class at the Philadelphia Hospital, with Listerism and the carbolic spray, the temperature did not rise above 102°. Now in his private hospital with rigid attention to cleanliness and thorough washing of the peritoneal cavity with hot water, the highest temperature will be below 100°. After operations involving the opening of the peritoneal cavity, if there has been any opportunity for the escape into it, of blood, pus or cyst contents, he washes it out thoroughly with hot water. After closing the wound he covers it with sublimated gauze and absorbent cotton and secures this with strip of plaster and a bandage. This dressing remains a week without need of disturbance. If gut sutures, or silk rendered aseptic by a coating of wax with car-

bolie or salicylic acid be used, there will be no trouble about suture abscesses. In a recent case, in which the abdominal walls were two inches thick from adipose deposit, these precautions were observed and there was not the slightest suture trouble. He does not now consider the spray of any value, because we cannot use carbolic acid solutions strong enough to certainly destroy the germs without poisoning the patient; and the spray only washes the germs down into the wound.

*Dr. Charles Herman Thomas* remarked that the experiments of *Dr. Sternberg* of the Johns Hopkins University, a careful and conscientious observer, have developed the fact that some of the antiseptic solutions in common use, three per cent. carbolic acid for instance, actually stimulated the growth of bacteria. Perfect cleanliness is the essential point, the foundation of surgical success. He has seen *Dr. Kelly* operate without disinfectants, his instruments placed in a dry pan, and his results prove the truth of the assertions he has made this evening.

*Dr. M. Price* has experienced great difficulty in his attempts to secure absolute cleanliness. He has seen half a dozen unclean hands introduced into a peritoneal cavity during operation, simply from curiosity, sponges picked up from the floor, napkins from a dusty window sill, instruments from a soiled blanket, and each used on peritoneal or absorbent surfaces; sponges that have been filled with pus used again in the peritoneal cavity, and in general extreme thoughtlessness in the little details of cleanliness that compelled the full power of antiseptics to bring good results. He has had good results in pyosalpinx even when purulent cysts have bursted in the abdominal cavity; but he allows only the operator's hands to enter that cavity, and practices the most thorough washing out with clean water. He has been burned by simply holding a carbolized ligature in his mouth for a few minutes, and feels sure that the retention of a number of such ligatures in the abdomen would be quite likely to give rise to trouble,

\*See page 110.

*Dr. Charles Meigs Wilson* said cleanliness by whatever means obtained is the greatest element of success in abdominal surgery. "As absolute cleanliness can be obtained by the use of agents possessing germicidal and anti-putriferative properties in the preparation of the atmosphere, the operator's person, the instruments, sponges and dressings; it seems to be the part of wisdom to employ such agents up to the time of and even during the operation. With a perfectly clean room and furniture, clean air, clean instruments, and clean hands, possibly no antiseptic agent would be needed. But unfortunately such conditions do not universally or generally exist and to attain them we must resort to the use of some efficient antiseptic. Care should be taken to employ some agent which is efficient and at the same time non-poisonous. In English and Continental hospitals where excessive antiseptic precautions are employed, the success attained compared with the previous mortality rate proves unquestionably the great value of such precaution. The united testimony of experienced American operators as to the value of antiseptic precautions should not be set aside. I believe that all instruments should be submitted to the purifying influence of dry or moist heat, that the towels, sponges and dressings should be left for twenty-four hours in a boiling hot solution of mercuric chloride 1 to 2000 and that the silk-worm-gut or fine wire sutures and ligatures should be kept in a very weak solution of carbolic oil. To my mind the terms antiseptic agents and aseptic are synonymous. My own experience has taught me that the best and least dangerous antiseptics are those which possess rather an anti-putriferative power, *i. e.* those which prevent or retard putriferative changes, rather than the more dangerous class of agents which possess decided germicidal powers.

*Dr. Parish.* Antiseptics are not intended to take the place of cleanliness. The greater the care bestowed on cleanliness in all details, the less will be the need for antiseptics. Boiled water, filtered, is a good washing material; patient, hands, and instruments must be

clean to insure good results. Absorbent lint wet at the time of using with a 1 to 2000 mercuric solution is a good external dressing. *Dr. Parish* agreed with most of *Dr. Kelly's* statements, but he believes in the value of antiseptic vaginal injections after labor in hospitals. The maternity wards of the Philadelphia Hospital showed a large number of deaths, varying from three to ten per cent. for many years prior to 1885; but last year in two hundred and forty-seven cases of labor there were but two deaths. One of these was after Cæsarean section in a patient who had been in labor nearly three days before she was brought into the hospital. The other fatal case was in an idiot and was largely from other causes than the labor which was not at fault. These good results are due to the use of mercuric chloride injections principally, although we have now new wards and opportunity for frequent change of nurses when advisable. In a case of septicæmia following adherent placenta, the patient seemed almost moribund but hot uterine injections of mercuric chloride, 1 to 4000, stimulated her and led to recovery. Water is boiled to destroy possible germs and filtered to get rid of various impurities not held in solution.

*Dr. M. Price* thought the heat of the injection used by *Dr. Parish* was the most important element in stimulating the patient; but the mercuric chloride would do no harm, and the fact that improvement commenced and continued from that time is the important point. The reaction against the use of antiseptics should not be allowed to go too far. They have done great good and cannot be discarded.

*Dr. Longaker* agrees with *Dr. Parish* and regrets to hear any disparagement of antiseptics. No reputable maternity can be conducted without them. *Dr. Lusk* considers that the poor woman delivered in a hospital, with the protection of antiseptics, is safer than the rich woman in her home with every other safeguard but without them.

*Dr. Soper*, formerly of the Rotunda, Dublin, upon invitation from the President, remarked that this was a very



mixed question. That neither cleanliness nor antiseptics could be dispensed with. He has seen cases do well under all conditions without antiseptic precautions and if the solutions are dangerous we must be cautious in their use. He believes thoroughly in cleanliness and would use antiseptics when he thought them needed. It does not do to run into extremes.

Dr. Kelly replied, in closing the discussion, that he was both surprised and gratified that so many members of the Society had expressed their approval of his paper. In two or three instances, however, he had been grievously misunderstood. He believes it to be the great glory and the crowning triumph of *antisepsis* to have discovered *asepsis*. He had nothing whatever in common with those surgeons who claim that antiseptics have done nothing. The peritoneum is a vast, exquisitely sensitive "culture" sac. In the old time chance decided whether the unclean hand of the surgeon carried in suitable germs to multiply in the medium, and the chances were greatly against the patient. Now the use of antiseptics accidentally involves rinsings and cleansings which make the surgeon a clean man in spite of himself; and the patient generally escapes. In a more advanced position, and the one in which the surgeon is living up to a *principle*, the utmost precautions are taken by a preliminary use of antiseptics in sufficient strength, and he goes to his operation needing no germicides.

Let the battle field be without the patient's belly and the germicide will there be sure of the victory every time. Statistics from foreign maternities as quoted, instead of proving against, are one of the strongest arguments for this position, for there the use of the germ destroying agent is wholly *without* the patient's body.

Dr. M. O'Hara reported a case of

EXTRA-UTERINE PREGNANCY WITH RUPTURE  
OF THE FALLOPIAN TUBE. LAPA-  
ROTOMY ON THE THIRTY-THIRD  
DAY. RECOVERY.

On September 25, 1885, Dr. O'Hara

was called to see R. H., who had good health, until seized, two hours previously, with severe rectal tenesmus, agonizing pains in the pelvis, pains from both flanks, and extending down the right leg and arm. From the tenesmus she thought she would have a stool and rushed for the water-closet, but no relief following, rushed to her room and fainted; she was carried to bed, rectal injections were given by those present but no movement followed, and opiates were given for the relief of the pain. When I saw her she was in a collapse, almost pulseless, respiration shallow, extremities cold. The whole surface was bedewed with a cold death sweat. She could not lie on her left side or back but reclined doubled upon her right side and would jump up occasionally with exclamations of agony. The history hastily gathered gave the following data. R. H. was 30 years of age, mother of three healthy children, the youngest one year old; she was still nursing it. She had never been sick and had menstruated regularly. One menstrual period had been missed about a week before the accident, and she considered herself pregnant.

The diagnosis was internal hæmorrhage due to rupture of the fallopian tube at the fifth week of pregnancy. Opiates and stimulants were used. The next day Dr. Parish was called in consultation and concurred in the diagnosis. There was still some shock, pulsation 130, feeble and irregular; respiration feeble; temperature normal, great pallor, evidently due to the loss of blood; the abdomen was moderately distended with occasional cramp-like pains; moderate tenderness, but no symptoms of peritonitis. The patient showed signs of reaction and laparotomy though discussed was deferred. Five days after the rupture the patient was able to bear a close examination. The abdomen was greatly distended; there was no tenderness on moderate pressure; resonance was general except in right flank where there was moderate dullness; there was no dullness in the left iliac and lumbar regions except very far back near the kidney. There was an apparent bulging

of the right flank. The vaginal surface was generally cedematous, the anterior wall of the vagina was thicker at the cervix and to the left. The cervix is moderately soft and patulous; no bulging of the posterior pouch. It was not deemed advisable to make use of the sound. The urine was almost black in color; pulse 104; temperature 99°; respiration normal. Two days later a marked jaundice appeared, although occasional vomiting and purging of bile occurred. A few days later a swelling was noticed on both sides and in front of the cervix; and a bloody painless discharge, containing decidua-like fragments escaped from the uterus and the dullness in the right iliac region disappeared. Urination became painful and difficult. The patient felt so much better that she desired to get up.

Three weeks after the first attack a terrible flooding occurred, it lasted for an hour, and slight hæmorrhage continuing afterwards. There was decidua in this discharge. At the same time the supra-pubic tenderness extended towards the right and slightly increased on the left side, extending upward as high as the umbilicus. Chills and a rise of temperature to 101°, vomiting, constant sharp cutting pains, and emaciation with signs of softening along the crest of the ileum and general appearances of blood poisoning occurred, and surgical interference was strongly urged as the only means of averting death. On the thirty-third day Dr. Parish operated and he prepared the following report of the operation.

There were present Drs. O'Hara, R. P. Harris, D. F. Willard, and McElroy. I proposed to cut down directly on the tumor by an incision immediately above the outer portion of Poupart's ligament, believing that the tumor consisted of blood coagula and pus located external to the peritoneum and that the anterior parietal peritoneum had been dissected up to such an extent that the mass could not be incised and emptied without opening the peritoneal cavity and without ensuring the possibility of objectionable fluid reaching the serous surface. I also believed that the peritoneal

cavity was clean and that there had been no general peritonitis.

The gentlemen present advocated a median incision, for purposes of exploration and in deference to their views, I first cut through the linea alba just below the umbilicus, making an incision long enough to admit two fingers. The peritoneal cavity was found empty and the peritoneum quite normal though somewhat congested. The exploring finger showed that the mass was external to the peritoneum and had extended upward from the left half of the pelvis to a level with umbilicus. The broad ligament had become obliterated by separation of its layers. It was not thought advisable to explore with the finger with the view of determining the condition of the uterus and ovaries and tubes. The peritoneal covering of the abnormal accumulation was evidently thin and tense so that a careful exploration as to the condition of the uterine appendages would have endangered its rupture and the probable development of general peritonitis. It would have been an easy matter to have stitched the parietal wall of the tumor to the walls of the median incision and to have then by incision emptied the mass of its contents. But such a procedure would have been attended with risk of leakage of the offensive fluid into the peritoneal cavity. To avoid this risk I now made another incision along the line of original election *i. e.* above the outer border of Poupart's ligament and readily reached the mass cavity without wounding the peritoneum. This incision was made long enough to admit two fingers. About one quart of blood coagula, fluid blood and pus escaped. The fibrinous masses were removed and all attached portions were scraped off with the fingers. The curette was avoided chiefly because of the thin upper wall. The cavity was washed out with antiseptic fluid.

The median incision was closed with sutures, a drainage tube was introduced into the mass cavity. An incision could not have been safely made through the vagina as the intervening tissue was too thick and its vascularity too great. The incision made admitted of more thorough emptying of the cavity.



The patient suffered no shock from the operation. There was a slight sanguinolent discharge, containing small clots from the drainage tube, amounting to about two ounces in twenty-four hours. Nourishment was taken fairly. The cavity left at the time of operation held  $\frac{3}{4}$  xxxij. In two days it had contracted to  $\frac{3}{4}$ i, but the discharge was purulent and offensive. A bloody discharge from the uterus had continued since the operation, but was free from odor and diminishing. The last sutures were removed five days after the operation and two days later the drainage tube was replaced by a tent. Two weeks after the operation the uterine discharge had ceased, but free bleeding from the wound occurred; there had been no exertion, sneezing or coughing to cause this hæmorrhage, which occurred about eight weeks after the last menstruation, but a week later a bloody discharge occurred from the uterus and wound. The temperature rose to 103°. There was no pain on pressure, but there was a suspicious hard spot in the left iliac region. Twenty-four days after the operation the patient was permitted to sit up, and while cheerfully singing felt blood streaming down her legs from the wound; clots passed also from the uterus and rectum. She felt the rectal tenesmus and pains in right lower extremity similar to those felt at first seizure. Much blood was lost. A similar bleeding occurred three days later, and as life was endangered it was thought necessary to give ether and explore the cavity. It was found that the tissues had been dissected up by accumulated blood and pus until the cavity extended down the side and front of the uterus, and communicated with the rectum at the upper end. The cavity was thoroughly scraped with a curette, and was then packed with alum sponges after disinfection with Platt's chlorides. The patient reacted well. When the wound was injected nothing came from the rectum, but an injection into the rectum came out of the wound, and there was a fecal odor about the wound. Next day the sponges were removed, and muslin tampons, wet with phenol sodique, were

introduced. The packing was changed twice each day. Discharges of offensive fecal matters and a small gall stone escaped from the wound.

On February 15, nearly four months after the operation, the patient is noted as doing uniformly well; the wound is closing; the exudation about the uterus and vagina is disappearing, and the odor and elimination of gas while dressing the wound had disappeared.

May 1. Patient has gained greatly in flesh, and presents the appearance of perfect health. A very small short sinus alone remains. The communication with the bowels has closed entirely. Menstruation occurs normally, and there is no bleeding at any time from the wound.

*Dr. Parish* made a few remarks on the history of this case, and the difficulties surrounding a diagnosis. The patient was thirty years of age and perfectly healthy. She missed one menstrual period, and a week later, possibly in the fifth week of pregnancy, there were signs of internal hæmorrhage with shock. Dr. O'Hara at this time made his diagnosis doubtless correct, of tubal pregnancy, with rupture of the cyst. The patient commenced after a few hours to rally. Dr. Parish was called in consultation the next day. He suggested an operation to remove the cause of the trouble, but did not urge it as the symptoms had ameliorated. The patient continued to improve for several days. Afterwards a tumor appeared. The first hæmorrhage being into the folds of the broad ligament and limited, did not show, but as repeated hæmorrhages occurred the tumor increased, pus formed, the embryo softened, septicemia without peritonitis was developed, and then the operation was performed, and was then imperatively demanded. Three months after the original shock a sudden and nearly fatal hæmorrhage occurred simultaneously from the wound, vagina, and rectum. Evidently there was a tubal communication between the uterus and the wound, and a large rectal fistula had formed. This fistula healed without any separate operation.

There was evidently at the beginning

a pelvic hæmatocele without peritonitis, due to a ruptured fallopian tube. The early operation was proposed, but did not meet with approval. It was evident the hæmorrhage was extra-peritoneal, as it would most probably have been fatal if it had burst into the peritoneal cavity. He deprecates the expectant plan of treatment of cases of rupture of the cyst of tubal pregnancy, but in this instance the amelioration of the symptoms at the time when first seen by him led him to hesitate as to the necessity for immediate operation. The sequel showed that in this case an early laparotomy would have been of no service. The patient's recovery is complete.

*Dr. Harris* heard of this case a week after its commencement, and believed from what he knew of it at that time that it would be advisable to perform the laparotomy; but subsequent developments indicated that the hæmorrhage was extra-peritoneal and gradual, and there was, therefore, no immediate danger to be overcome. When, however, he saw the patient, October 28, he was satisfied that her constitutional symptoms required that an exploration of the abdominal cavity should be made, the blood cyst defined, and then that the blood should be evacuated above the left groin. This opinion being sustained in the consultation, the operation was performed accordingly.

*Dr. Price* inquired if any examination of the gall-bladder and duct had been made at the time of operation. Was the jaundice due to mechanical obstruction or to the general condition?

*Dr. Baer* at first thought an error had been committed in not operating at first when the diagnosis was made and the tube ruptured; but the full history puts the matter in a different light, and would cause great hesitancy about rushing in in a similar case.

*Dr. O'Hara* had made his diagnosis at the time of the accident. Operation could not have been performed then on account of the collapse, and after that passed away it did not seem called for until the time of its performance. One question has risen in his mind from the subsequent history of the case. Would

it not have been better if the wound had been packed from the time of the operation?

(To be continued.)

RECTAL EXPRESSION.—Dolérís, in a number of the *Répertoire Universel d'Obstétrique et de Gynécologie* for March 10th, advises, as one of the means for preventing tears of the perineum, delivery of the head of the fœtus by rectal expression. He attributes the method to Olshausen and Ahlfeld, and describes it as consisting in the introduction of two fingers into the rectum of the parturient toward the end of the expulsive stage, carrying them as far as the mouth or under the chin of the child through the recto-vaginal wall. Therewith these fingers drawn in front and above, and by suitably directed gentle pressure, the deflection of the head, which is gradually elevated to the pubic arch, is effected or completed. The free hand may be used to assist this deflection. Two points are urged by Dolérís in rectal expression: First, let it not be done in the interval of contractions; second, let it not be begun until the posterior angle of the anterior fontanelle is fully in the commisure.

Of course, the use of the fingers in the rectum for the delivery of the head is much older than the practice of Olshausen and Ahlfeld, but we have never been able to see how this method in itself furnished any greater security for the safety of the perineum than spontaneous delivery does. It can by no means increase the circumference of the vulvo-vaginal ring, and when that circumference is equal to the circumference of the fœtal head, the latter passes through without doing injury to the former. External means are quite as efficient in retarding the exit of the head until the orifice, through which it is to pass, is sufficiently dilated, and in guiding the head in the axis of the final portion of the birth canal, while they are much less repulsive; art should be an imitation of nature, and nature gives no hint for the performance of rectal expression.—*Med. News*, May 15, 1886.



## MARYLAND MEDICAL JOURNAL

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BALTIMORE, JUNE 5, 1886.

## Editorial.

**OPERATIVE FIXATION OF A MOVABLE PORTION OF THE LIVER.**—The solid organs of the abdomen are liable to become displaced, and to give rise to symptoms more or less distressing and dangerous. Whilst separation of any of these organs occurs only as a rare accident, the condition called floating or wandering kidney is by far the most frequent. The liver also occasionally becomes loosened from its moorings and occupies an abnormal position. Such serious symptoms are sometimes produced by an undue mobility of the kidney that its extirpation has been suggested and, unless we are in error, actually performed. In fact in glancing over the table of 100 nephrectomies for all causes recorded by Dr. R. P. Harris in the *American Journal of Medical Sciences* for July, 1882, thirteen were on account of "painful floating kidney," and Billroth, in *Wiener Medizinische Presse*, Nos. 23, 24 and 25, 1884, states that the operation of nephrectomy for wandering kidney had been performed fourteen times with eight recoveries. As this operation is in itself not only dangerous, but deprives the patient of a functionally perfect organ, efforts have been made to secure the kidney in its normal position. This is called nephrorrhaphy, and was first performed by Hahn, of Berlin, in 1881, but as yet the results do not speak highly of the procedure. The operation, however, is performed in much the same manner as if nephrotomy

or nephrectomy was to be attempted. An incision is made in the loin, and when the capsule of the kidney is reached catgut sutures are passed through the fibrous envelope of the organ, and stitched firmly to the posterior abdominal wall. Up to the present, as far as we are informed, no effort has been made to secure the liver in its normal position by operative means, with the exception of the case which is about to be mentioned. Through the courtesy of Dr. V. R. von Hacker first assistant at Professor Billroth's clinic, our attention is called to a paper in *Wiener Med. Wochenschrift* Nos. 14 and 15, 1886, a reprint of which he kindly sent to us, entitled "Operative Fixirung eines beweglichen abgeschnürten Leberlappens." This paper is based upon a case in which Billroth sutured a portion of the liver to the abdominal walls in order to relieve the distressing symptoms incident to too great freedom of motion. Upon March 21st, 1884, laparotomy was performed for a tumor occupying the upper and right side of the abdomen, which was supposed to be a neoplasm of the kidney, intestines or retroperitoneal glands. Upon opening the belly, the tumor was found to be a portion of liver which was so nearly detached, as to allow a great range of mobility. The patient was a female, 36 years of age, who had borne three children. She enjoyed excellent health until within a year, when she frequently experienced vomiting and fever without known cause. For five months she had noticed a lump about as large as an apple in the upper abdominal region; besides these symptoms she suffered pricking and dragging pains extending from the back to the sternum and from the sacrum down the thighs, which rendered going up stairs and working almost impossible. She had emaciated considerably, and often felt faint and weak. The liver dullness reached to the lower border of the ribs. In the right mammillary line the dullness reached downwards almost to the iliac spine. Upon palpating the region corresponding to the dullness, a hard tumor, larger than a fist was felt which moved with the respiration, and could be easily pressed backwards into the

position of the kidney, where its impulse could be distinctly felt by the other hand. The tumor was of firm consistence and of uneven and rough surface. The diagnosis by both surgeons and physicians was a neoplasm, as stated above. Upon opening the abdominal cavity by an oblique incision running from near xiphoid cartilage towards the anterior superior spine of ilium, an irregular, rough tumor of brownish red color was seen, which was found to be connected with the liver by a bridge of tissue, and upon closer examination was discovered to be a detached portion of liver substance which had been separated either by the constriction of the clothes or as the result of syphilitic disease. The attempt was now made to fix this liver flap to the abdominal walls, in order to prevent the injurious mobility of the same. A strong suture was passed deeply into the substance of the flap and its two ends passed entirely through the front abdominal wall and tied over a pad of iodoform gauze. The after course of the wound was favorable and in four weeks the patient left the hospital cured. The distressing symptoms, pain and vomiting ceased and at the date of writing, a period of two years, had not returned. It will be seen that two operative procedures were available for the treatment of this case, the one mentioned above, that of attaching the liver to the abdominal walls with sutures; or the resection of the loose portion of the liver. As the removal of a large portion of the parenchyma of the liver had never been performed, and appeared to be more dangerous than fixation by sutures, the latter method was adopted and with most satisfactory results. Dr. von Hacker likewise enters into a review of the literature on the subject of operations upon the parenchyma of the liver, but time does not suffice us at present to do more than mention the rest of his interesting paper.

Dr. W. O. Baldwin, an ex-President of the American Medical Association and one of the best known physicians in the South, died at his residence in Montgomery, Alabama, on May 29th.

## Medical Items.

M. Ranvier has been elected "membre titulaire" in the Pathological Anatomy Section of the Paris Academy of Medicine, the unsuccessful candidates being Voisin, Grancher, and Hanot.

Dr. E. G. Janeway, acting on a suggestion from a colleague practicing in the country, has given frozen milk to patients whose stomachs did not tolerate ice-cream, and speaks highly of its use in fevers.—*N. Y. Med. Journal.*

Dr. Henry G. Landis, Professor of Obstetrics and Diseases of Women in Starling Medical College, died at his residence in Columbus, Ohio, on May 22d. Dr. Landis was the author of several works on Obstetrical subjects, which were well received by the profession.

The *Lancet* states that it is reported that M. Pasteur has been so favorably impressed by the scientific intelligence of an American physician, Dr. Valentine Mott, that he has for the first time, broken through his rule not to allow his virus to go out of his own hands.

Dr. W. G. Rider a well-known physician, of this city, died at his residence in Baltimore County on the 31st of May. Dr. Rider at one time enjoyed a large practice in this city. He retired from practice after some forty years of medical work and for the past five years has lived in Baltimore County.

The fourth annual meeting of the Maryland State Pharmaceutical Association was held in Annapolis, on June 1st. The meeting was well attended. Dr. A. J. Corning, of Baltimore, was elected president for the ensuing year. The next annual meeting will be held at Ocean City, Md., on the third Tuesday in July, 1887.

In the German and German-speaking universities, by far the largest medical faculty is that of Vienna, which has 18 professors, 34 extraordinary professors, and 82 privat-docents, making 134 teachers; the number of students being 2,307. Next comes Munich, with 13 professors, 7 extraordinary professors, and 22 privat-docents, making 42 teachers; the number of students being 1,129. After this comes Berlin, with 1,072 students, and no less than 100 teachers. The smallest of all appears to be Rostock, with 11 teachers, and 92 students.—*Med. News.*

The *Medical Record* states that a movement is on foot to establish a "Pasteur Institute," in New York City, and that an appeal to the public for \$5000 is to be made. The names of the movers in this scheme are not given. It was authoritatively stated a short time ago that Pasteur was for the present unwilling to have any other institute established than that in Paris. It is not probable the New York "Pasteur Institute" will prove a success.



## Original Articles.

PERIODICAL HYPERÆSTHETIC  
RHINITIS.\*

BY JOS. BLUM, PH. G., M. D., OF BALTIMORE.

Already aware of the innumerable papers and pamphlets written and circulated, bearing upon this subject, I undertake from personal experience to make some practical remarks upon the same, feeling myself, to my sorrow, peculiarly well fitted to deal with the subject of my paper in a comprehensive and practical manner, to which I invite your attention.

Having been a victim of this unwelcome annual visitor for the past twelve years, and having three friends similarly affected, I manifested deep interest in this disease long before I adopted the profession in which I am now engaged.

Previous to that time I dealt with it in a practical manner; now I deal with it in a somewhat theoretical manner, but the ultimate results from either treatment have not been as pleasing as could be desired. I can give no better or more comprehensive definition than that of Dr. Geddings, of N. H., in his article upon hay asthma, contributed to the recent excellent work of Dr. Pepper, which reads follows: "Hay asthma is a form of catarrh appearing in the spring, early summer or autumn, attacking persons predisposed every year at the same time, the patient being at other times free from the disease, characterized by symptoms resembling those of influenza, the chief of which are sneezing, redness, swelling, and increased secretion of the conjunctivæ, and the mucous membrane of the entire respiratory apparatus from the nose down to the minutest bronchi, frequently culminating in more or less severe attacks of asthma."

The interest recently manifested by the profession in the disease, is no doubt due to the increasing number of victims

annually appealing to the practitioner for relief or possible cure. Not many years ago the practitioner diagnosed and treated the disease as a common cold or coryza, and I regret to say, with almost as much success as hay fever up to quite a recent date was treated. I remember that when in 1880 I confronted my medical adviser, one too of high standing, and stated I would like to be cured of hay fever, he replied: "My dear boy if I could cure hay fever I would be a millionaire in a comparatively short time." Upon this reply, I, like all ambitious youths, eager to make lots of money in the shortest period of time, set to work experimenting with drugs and chemicals, without knowing the pathology of the disease; but like my learned medical adviser, I found that the cure of hay fever would never reap me a fortune. From statistics which I have borrowed from the work of Merrill Wyman, the then prevalent idea that it was a disease of the cultured and educated members of society, seems somewhat plausible, from the fact their temperament is more nervous than that of the multitudes engaged in manual labor.

Previous to 1860, the fact that the disease was unknown in Germany, where it is now known as "Hen Schnupfen," is substantiated by the honest confession of Phoebus, when confronted by a colleague suffering with the disease, that he was not acquainted with the disease, neither was its name familiar to him.

Of late hay fever has become as familiar and popular among the fashionable and intelligent classes as malaria and Bright's disease among the laboring classes. I will not enter into detail as to its etiology, nor touch upon the pathology at all, but to those interested I could commend no better work than the recently published one of Dr. Chas. Sajous, of Philadelphia, or Merrill Wyman's, a sufferer like myself.

As to the cause of this disease, I am, and always have been at a loss, and from the literature I have read upon the subject, my conclusion is that all authors are at a loss as to the definite

\*Read before the Clinical Society of Maryland, April 16, 1886.

cause of this torturing malady. One will favor the "Pollen theory," and among the advocates of this theory are such learned authorities as Morrell Mackenzie, Moore and Blackley; others are advocates of the "Thermic theory;" others advance the neurotic theory, and this I deem a true one to the extent that a neuroses predisposes to the disease. This theory was advocated by Dr. John N Mackenzie, of this city, and published in the year 1884 in the *N. Y. Medical Record*. Another advocates the individual peculiarity of the sufferer.

In its heredity I have no faith, unless the attack is accompanied or complicated by asthmatic symptoms, and I am strengthened in this opinion from the fact of having ten cases under my observation, in only three of which cases could the disease be traced back to the ancestors, and all three of the cases gave evidence of asthma.

Being exposed to the same causes of this disease as multitudes of others are, it most assuredly must besome peculiarity in the person so affected, but up to the present such peculiarity has not been discovered.

I remember some years ago encountering in my flights to the mountain tops, a negro afflicted with hay fever, a curiosity from the fact of not hearing or reading of another case among the African race. The disease is more common among males than females, and affects primarily those between the ages of 15 years and 40 years. From Wyman's statistics I note the fact that among ten professions the physician and medical teacher takes the precedence of all others in the percentage of victims of hay fever.

That the pollen is a cause, I almost hesitate to differ with such high and learned authorities as Blackley, and Morrell Mackenzie, but that the excitant of an aggravated attack I submit, as a case now in my recollection, some years ago under my observation will illustrate: A lady whose husband is engaged in the grain business and has his storehouse well stocked with hay, straw and oats, has her symptoms aggravated by his presence, or the removal of his clothing in her bedroom before retiring.

A peculiarity of the disease is the regularity of its invasion and recurrence. In the aforesaid case and my own the attacks recur annually on the 19th of August.

With those who hold that heat is the cause, I also disagree, but like the pollen it most undoubtedly aggravates the attack. The rays of the sun, or of artificial light falling into the room or upon the face of the victim will aggravate the attack. The electric light is innocent as compared to candle or gas light. My experience, like many others, has been such that a cloudy or rainy day is far more welcome to the sufferer than the sun in all his brilliancy, the symptoms being less in severity on such days. Having spent five years in the pharmaceutical laboratories of Messrs. Sharp and Dohme, of this city, where I manipulated and compounded many drugs and chemicals, my attacks were so severe at times that I was compelled to withdraw from the establishment for an hour or two. I noticed this especially in handling ipecac, quassia, senega, guaiac, or preparing the green or red iodide of mercury; a fact which would somewhat substantiate the pollen theory.

The first intimation that my foe is confronting me is a paroxysm of sneezing, malaise and languor, soon followed by the army of symptoms, such as a tickling sensation in the fauces, nostrils, a roaring sensation in the ears. In the region of the frontal sinuses there is a sense of fullness shortly after these initiatory symptoms; the secretions from the eyes and nose become excessive and slightly acrid, constantly trickling down the face causing excoriations of the adjacent parts.

The victim whilst suffering will seek solitude, avoiding his friends, and if possible his family. I have at times been melancholic, refusing to dine at the family table, and secondly from loss of appetite, which leaves me in a relaxed and depressed state after the siege has been fought.

As to locations exempt from the disease my knowledge from experience is very limited, having only visited the



mountains of our own and adjacent states.

I visited Deer Park and Oakland situated in the extreme west of this state, in Garrett County, at an elevation of 2,500 feet, and a temperature of 50° F. but my attacks were quite as severe, perhaps more so than when I reached the resorts, necessitating my return home before the week had ended. I also visited the Blue Mountain House, situated half a mile from the popular summer excursion resort Pen-Mar, with a similar effect. The next place to which I took flight, was at the request of my former kind and sympathizing preceptor Mr. A. P. Sharp, to his country seat at Rock Hall, Kent County, situated about ten miles from Tolchester Beach and about twenty-five miles from Chestertown. At this place I enjoyed comparative ease, as my symptoms were not so severe, which I attribute to the moisture emanating from the soil so adjacent to Rock Hall Creek, a tributary to the Chesapeake Bay. Since my last visit to this place Mr. Sharp has made the observation that the atmosphere from Tolchester Beach on the Bay shore, to the north of Chester River is well charged with ozone. He also informs me that the physicians of Kent County, are not acquainted with hay fever, and have encountered very few cases of neurotic asthma or phthisis.

Last year I took a trip to Europe, and on my return sailed from Bremen on 13th of August for America; although as I have previously stated my attacks regularly began on the 19th, on this occasion I experienced not the slightest symptom of hay fever until the 27th of August, when Sandy Hook was in sight and then the disease attacked me in all its severity. This was sufficiently conclusive that the Ocean did and does afford complete exemption, and I would advise such a voyage to those suffering, and finding such a voyage convenient.

As the greater number of my hearers are like myself engaged in the general practice of medicine, and we do not possess the galvano-cautery, or other surgical appliances, neither have we acquired the skill and dexterity in man-

ipulation of the rhinoscope and cautery, etc., as the specialist in the use of the same, I will therefore limit my remarks to the medical and hygienic treatment of the disease which will undoubtedly confront us during the approaching months of June, July and August.

For convenience I will classify the treatment into local and general. The following receipts I have compounded and used whilst engaged in pharmacy :

℞. I. Quin. Sulphas - ʒi  
Morphia Sulphas - gr. i

M. Use as a snuff.

I have also used this in solution.

℞. II. Bismuth Subnitras - ʒii  
Pulv. Acacia - - ʒi  
Morph. Sulphas - grs. iv

. Sig: Use as a snuff. This was more satisfactory than ℞ I.

℞. Iodine Resublimed - ʒi

In a bottle filled with absorbent cotton and the vapor inhaled. The good effect was only momentary.

During the remaining four weeks of my attack in 1885 I used a four per cent. cocaine nasal suppository, and a four per cent. oleate of cocaine dropped into the nasal cavity with a pipette whilst in the recumbent position. The cocaine constringing the turgescent blood vessels, and shriveling the mucous membrane thereby obtunding the sensibility of the hyperæsthetic nerve fibrillæ situated in that organ. As a collyrium I have used the following.

℞. Boric Acid - - ʒi  
Aqua Rose - - ʒi

℞. Sodii Biborate - - ʒi  
Spts. Vin. Gallici - ʒss  
Aqua Camphor - ʒi  
Aqua Puræ - ʒi

A few drops into each eye t. d.

An infusion of green tea applied externally with a piece of lint had a soothing influence, no doubt due to the effect similar in its analogue erythroxylon coca.

Before retiring apply oleate of zinc ointment to the margins of the eyelids to prevent their adhesion in the morning, and if such adhesion should occur I use a lukewarm solution of bicarboras sodæ to the eyes.

As to the naso-pharyngeal and ophthalmic symptoms, internal medication has proved unavailing, but in cases accompanied or complicated by asthmatic symptoms, internal medication is highly essential, and for this purpose I can commend the following:

Morphia or codeia heads the list, but its administration should not be left to the patient's indiscriminate use. Bromide of potash or soda, valerianate of zinc or ammonia, Fowler's solution, fld. ext. coca, or fld. ext. grindelia robusta.

R.	Stramonium Leaves	-	3i
	Belladonna Leaves	-	3i
	Lobelia Leaves	-	3i
	Anise Seed	-	3i
	Tobacco Leaves	-	3ss

These to be mixed and powdered, then saturated with 3ij of Potass. Nitrates in solution, then dried and a teaspoonful ignited, and inhale the smoke before retiring.

As an alterative I have used:

R.	Potass. Iodid.	-	3ii
	Tr. Rhei	-	3ss
	Tr. Cinchona Comp'd	-	3iiss
M.	Sig.	-	3i t. d.

This was also the tonic used by me.

In regard to hygienic treatment I have little to say. It is customary with me to take a cold bath every morning during the season, using the friction brush and turkish towel quite vigorously, an unpleasant ordeal I confess, but an invigorating one, giving me an appetite for a light but nutritious breakfast consisting of milk, soft boiled eggs and Vienna rolls or graham bread.

My suppers are extremely light owing to the insomnia and restlessness produced by an overburdened stomach.

During the entire season I use the London smoke glasses, which protect my eyes from the rays of the sun, also particles of dust floating in the atmosphere.

Marshall Lodge of Masons, of Lynchburg, Va., has established a Home and Retreat for the Sick and Wounded under the management of a Board of Managers, of which Dr. C. E. Busey, formerly of this city, is secretary. The Institution is known as Marshall Lodge Home and Retreat and is located at the corner of Church and Fourteenth streets.

## A PIECE OF METAL IMBEDDED IN THE CORNEA WITHOUT PRODUCING IRRITATION.

BY HERBERT HARLAN, M. D.,

Surgeon to Presbyterian Eye and Ear Hospital, Demonstrator of Anatomy University of Maryland.

Chas. S., colored, aged 17, came to the office with the request that I would see if I could do anything to take off a spot from his eye. He stated further that he could see all right and that the eye was not in the least painful. He merely wanted the small white spot taken off. He said he had been struck in the eye two years previously with a ball, and that the spot had been there ever since. On examination I saw what, at first glance, I took for a corneal opacity, but a shivering appearance made me look closer, and then I felt sure I had to deal with a foreign body, possibly a seed husk of some kind, though the boy insisted this could not be. There was not the slightest irritation, and as it was located below the pupillary area, the sight was not interfered with, v.  $\frac{20}{20}$ . I instilled one or two drops of cocaine solution, and after a few minutes I removed without difficulty a thin shining piece of metal, rather larger than a pin's head and irregularly triangular in shape. I then showed the patient first the metal and then the place on the cornea from which it had been detached. He was very much surprised, but still insisted the spot had been there two years, and had followed a blow from a ball. This statement must, of course, be taken for what it is worth, but there is no doubt that a thin scale of metal was imbedded in the cornea for a considerable time, and without any irritation being produced.

According to the *Novosti* a man has just died in the St. Petersburg poorhouse at the age of 122; he had been an inmate since 1818. He retained his senses to the last. Indeed it was only about four years ago that he seemed to fail at all, having till then enjoyed excellent health. There is still living in the poorhouse a soldier's wife, who is shown by documentary evidence to be fully 110 years of age.—*Lancet*.



## Society Reports.

## THE CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 16, 1886.

*(Continued from last issue.)*

The President, DR. L. McLANE TIFFANY, in the chair.

*Dr. Joseph Blum* read a paper on

## PERIODIC RHINITIS.\*

giving his personal experience as a sufferer from the disease.

## TREATMENT OF CARBUNCLE.

*Dr. Wm. H. Norris* wished to call attention to very satisfactory results he had recently obtained in the treatment of two large carbuncles by the carbolic acid method.

They were very large, one being 4 by 6 inches, the other somewhat smaller. The acid in solution was injected into and around the carbuncle, and in two days they were converted into healthy open granulating ulcers, that rapidly healed.

*Dr. Pole* has had good results from the use of caustic potash in these troubles.

*Dr. G. H. Rohé* considers cutting with the internal administration of quinine and iron the proper treatment for carbuncle. He protests against the use of caustic potash because of its being an unsurgical procedure whose action can not be controlled after it is once applied.

*Dr. John Chambers* questions the accuracy of the diagnosis in many of the cases of carbuncle reported as cured by the carbolic acid method. He don't think it quite so common an affection.

*Dr. Randolph Winslow* sees good in both lines of treatment; but in many of those affected with carbuncle we have patients who could hardly bear the loss

of blood sometimes consequent upon the cutting treatment. He considers the carbolic acid method ordinarily a good line of treatment.

*Dr. L. McLane Tiffany* don't think any recent observer justified in claiming originality for the use of carbolic acid in carbuncle. He recalls a case treated after that method by him in 1867, and it was not then original with him.

It was introduced for its germicide effects, upon the ground that carbuncle was the result of the presence of a coccus in the tissues. The plan is to inject with a hypodermic syringe a 10 per cent. solution of the acid into and around the diseased area. It causes sloughing and usually converts it into a healthy granulating ulcer. It is less painful than the knife and as good in its results.

## FAILURE OF EMETICS IN STRYCHNIA POISONING.

*Dr. Strauss* called attention to the failure of emetics in a case of strychnia poisoning recently seen by him. The patient was supposed to have swallowed about 45 grains of strychnia. Two minutes afterwards he had opisthotonos. Apomorphia was given hypodermically without effect. An effort to pump out the stomach was made but the spasm of the oesophageal muscles was so great that the tube was compressed and no fluid could be brought away. The patient died of asphyxia in half hour.

*Dr. Wm. Massey* reported a case of

## HYSTERICAL APHONIA.

in which the treatment recommended by Dr. Flint in his Practice of Medicine accomplished a cure.

The treatment referred to is, when all others failed then resort to alcohol to intoxication. The doctor acted upon this suggestion and on the following morning the woman was in her natural voice.

Under the head of miscellaneous business Dr. F. A. Morawetz was appointed a delegate to the Medical and Chirurgical Faculty of Maryland.

\*See page 121.

## OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, HELD MAY 6, 1886.

*(Continued from last issue.)*

The President, B. F. BAER, M.D., in the chair.

## SÄNGER'S CÆSAREAN OPERATION.

*Dr. Robert P. Harris* said, I desire through this Society to give publicity to the following statement, received a few days ago in a letter from Dr. Säger of Leipzig, by which it will be seen that his method now stands unrivalled in the world, in its ability to save human life. Locally considered, the Porro operation as performed in the Santo Caterina Hospital of Milan, Italy, has until recently far exceeded, in its proportionate success, all other Cæsarean methods in any hospital or country but this, the best of all Porro successes, has now to be rated second as compared with its younger German rival. Laparo-elytrotomy a year ago, stood upon the same footing with the Säger operation, in its rate of success; but now the latter far out strips it in the number of times it has been performed, and in its proportion of cures. According to Dr. Säger's letter, his operation, with its modifications and simplifications has been performed twenty-five times, saving eighteen women, or 72 per cent. and resulting in twenty-two children being delivered alive, or 88 per cent. In these are included three fatal American cases, which if not in absolutely hopeless state before the operation, gave a very minimum hope of success. The European twenty-two operations saved eighteen women or 81½ per cent. In the Maternity Hospital of Leipzig, Dr. Säger has operated four times, Dr. Obermann once, and Dr. Donal once, saving all of the women and children; in but one woman was there any special trouble after the operation. Dr. Leopold of the Dresden Maternity Hospital has operated nine times and Dr. Korn once; the former lost one woman; all of the children were saved. Thus we have fifteen women and sixteen

children saved under sixteen operations, a mortality for the former of only 6½ per cent. Of the four deaths in Europe, two resulted from sepsis poisoning which existed at the time of operation and in the other two subjects it followed it.

Dr. Säger has such confidence in his method from the success that has attended it in Germany, that he believes the time has come, when it should be preferred to craniotomy, because of its moderate fatality, and its saving the child. We should be glad if all of the Cæsarean operations of the United States should be performed after Säger's method as simplified by Garrigues and Leopold; but we must not accept very happy results here, until our accoucheurs become alive to the fact, that delay in operating will make any method fatal in a large proportion of cases. In no country are the capabilities of the old Cæsarean operation greater than in the United States, and in few, has this form of delivery been of late more uniformly fatal. To find eighteen recoveries under it we must search backward to January 1863, and through a record of time covering more than twenty-three years, in which period seventy-three operations have been performed proving fatal about 75 per cent. This occurred notwithstanding an established fact that a set of early operations will save 75 per cent. of the women and still higher of the children in the United States.

## TAIT ON FARADIZATION.

*Dr. R. P. Harris* also presented the following letter from Mr. Lawson Tait, of Birmingham, dated April 16th, 1886. "I have very strong objections to the proposal to treat cases of extra-uterine pregnancy by faradization. In the first place, the diagnosis of these cases must always be haphazard, that is to say, a correct diagnosis will not be probable more than once in three times; the result will be that all such cases will be dealt with mischief only, and I venture to predict that this treatment will be dropped as all such treatments are, without explanation of the case in a



very short time." "My greatest objection is, that supposing the fœtus has passed through the stage of tubal rupture and remained alive, what right have you to murder that child? If it goes on to the full time it may be delivered alive and the woman will have a chance of recovery from the operation far greater than with the faradization treatment of destroying the child. The cases according to my experience which recover from the operation are about six out of seven."

"Every one, who has had much experience with pelvic tumors must have seen a certain number of cases where the fœtus has died between the fourth and six month, and where after a prolonged course of suppuration it comes out through the rectum, bladder, etc., these are of course the cases where the tubal rupture has taken place into the broad ligament on the left side. I have seen one right sided case going into the bladder; it of course killed the patient."

"In the whole course of my life I have only known of one case where the woman has carried an extra-uterine pregnancy for a number of years after the death of the fœtus. We know with perfect certainty all about this case, and for about eighteen years she has carried on the left side a condensed ovum of extra-uterine pregnancy. I doubt very much if there could be found in the whole world three other such cases; whereas the number of cases who die or who have prolonged illness, after the suppuration and discharge of the fœtus, is even in my own experience very great."

In closing his letter Mr. Tait writes, "I wish you would make the opinion of mine known on your side."

In reply I will state, 1. We do not in this country, practice electrolysis in cases of extra-uterine pregnancy. No puncturing needles are used, and the electro-magnetic current will not endanger the life of the patient any more if the growth to be acted upon is a tumor, than if it be as presumed, an ectopic fœtal cyst. The experience of seventeen years in the United States, in which no fatal result is believed to have taken place,

has only tended to establish the fœticidal method as a valuable means of saving women when in great danger of death from rupture of the fœtal cyst and internal hæmorrhage.

2. We do not propose to act upon the fœtus after it has escaped into the abdominal cavity, unless the fœtus should be very small, and be easily accessible to the pole of the battery placed in the vagina. We cannot see that it is any more a murder to destroy a two or three month's fœtus after it has escaped from a fallopian tube by rupture, than while it is still in it. The chief objection lies in the fact that such an ectopic fœtus will be much more likely to give trouble after its destruction, than one that is scarcely enclosed in a sac from which the amniotic fluid shall have been absorbed. It is true that an abdominal fœtus may be delivered alive at term, if permitted to live, but it is not correct to estimate the risk of such an operation as lower than faradization properly performed, for it is far higher. Primary laparotomy as far as we know of the operations, has been fatal in fifteen out of nineteen cases.

It is not proposed in this country to operate by faradization upon fœtuses of from four to six months. Dr. T. G. Thomas, has it is true proposed to make the limit four and a half months, but the general impression is, that feticide is much safer immediately and remotely, if done in the second and third months, when fœtal ossification is very incomplete. The entrance of fetal debris into the bladder is not necessarily fatal as in the case related by Mr. Tait, for Parry refers to nine cases four of which recovered.

Mr. Tait appears not be aware of the fact that cases of prolonged ectopic gestation have been comparatively numerous, as witness the following partial record.

1. Nabel reports the case of a woman of 91 who died in 1767, and in whose body a fetus was found, that she had carried fifty-five years. (Campbell on Extra-uterine Pregnancy, 1840, page 45).

2. Brandt records one of a woman of

80, who died in 1858, after carrying a fetus for fifty-six years, and bore two children while it was still in her abdomen. (*Ranking's Abstract*, 1863, vol. I, page 216).

3. Parkhurst reports one of a woman of 77, who carried a fetus fifty-two years. (*British and Foreign Med. Chi. Rev.* 1856, vol. I, page 271).

4. Chiari gives a case of a patient who died of pneumonia when 82, who carried an eight months' fetus for fifty years. (*Lancet*, Lond. 1876, vol. II, page 141).

5. Conant's case was a woman of 63, who died in June, 1863, after carrying a fetus thirty-five years. (*New York Med. Jour.*, May, 1865).

6. Majon found in woman of 78 a calcareous fetus computed at three months. (Cruveilhier. *Essai sur l'Anatomie Pathologique*, Paris, 1816, tome II, page 130).

7. Mangin Vernier found two fetuses in the body of a woman of 74, which she had carried thirty-three years. (*Jour. de Medicine*, 1786. *Gaz. Med.* July 29, 1837).

8. Morand also found a three months fetus in a woman of 78; she had carried it thirty years. (Mem. de l' Acad. Roy. des Sciences, 1748).

9. Kristian Grön found a three months' fetus in a woman of 49, which she had carried eighteen years. (*Norsk Magazin for Lægevidensk* Band XVII, Haft 2).

10. Johannis Ambosi (1582) reported a case of a woman of Sens, who carried a fetus twenty-eight years. (See Astruc, *Traite des Mal. des Femmes*, Paris, 1765, tome IV p. 78).

11. Cambell reports the case of a woman of 75, in whom was found a fetus that had been carried thirty years; a fetus of about two months was also found. (C. on Extra-Uterine Gestation, Edin. 1840, p. 55).

12. Pepper relates the case of a patient of 53, married twenty-seven years, in whose body Dr. Loder found two fetuses, one carried twenty-three years. (Trans. Pathol. Soc. Phila., 1876, page 102.)

13. Francis Bayle removed an eight

pound fetus, after the death of a woman, of Toulouse, that she had carried twenty-six years. (Philos. Trans. Abrid. London, 1794, vol. III p. 222).

14. Cruveilhier in his *Anatomic Pathologique*, gives a plate representing a calcified fetus which had been carried many years.

15. Céligner reports the case of a woman who carried a six and a half months' fetus about fifteen years. (Prog. Med., Paris, 1884, vol XII, p. 196).

16. Johnson's case, aged 58, carried a fetus fourteen years, after which she discharged foetal remains at intervals during thirty years. (*Med. Times*, Lond., 1872, Vol. I., p. 655.)

17. Leinzell, in 1720, removed from the body of a woman, of 94, a foetus that she had carried for forty-six years.

18. Watkins examined a woman, of 74 who died of kidney disease, January 13, 1866, and removed a foetus which she had carried for forty-three years. (*Brit. Med. Jour.*, March 3, 1866.)

19. Van Sweiten also records the case of a woman, of Lyons, who died at 68, and had carried a foetus for twenty-seven years (*opus cit.*)

21. Fabri, of Ravenna, found in a woman, of 55, a foetus she had carried for some years. The pregnancy was her fifth, and she bore two children at later periods. (*Brit. Med. Jour.*, March 7, 1863.)

Many more cases of the same character might be added to this list, some of which would go to show that an extra-uterine foetus may prove fatal by purulent disintegration and pointing after twenty years or more. Even an ectopic foetus of three months may cause perforation of the rectum and possibly a fatal issue, although this is a rare result; it will be noticed, that in three of the twenty-one cases the foetus was computed at three months, and in another, a second foetus was of two months.

Dr. O'Hara exhibited a

#### FIBRO-CYSTIC TUMOR OF THE UTERUS

removed after death from a patient, æt. 53 years, who had carried it for over twenty years. Three years after it was



first observed she applied to Dr. Atlee for relief by operation; but he declined and recommended that it should be left alone. The tumor contained numerous small cysts, and measured  $39\frac{1}{2}$  by 34 inches in circumferences, and weighed 30 pounds. The peritoneum was  $\frac{1}{4}$  inch in thickness and was of a yellowish white color.

Dr. Parish remarked that the tumor had formed no adhesions, with the exception of a few slight ones to the omentum, and the removal of the ovaries and tubes would have been feasible at any time. Both tubes were dilated and in a condition of hydro-salpinx. The tumor sprang from the fundus uteri, the cavity measuring only four inches. The tubes and ovaries had remained at their normal position in relation to the uterus, but had been elevated out of the true pelvis. The vagina had been stretched upwards, as also had been the uterine body and neck. The uterus below the fundus had diminished in size to about that of the index finger. The bladder, by reason of the traction upwards, had lost its attachment to the uterus, and merely retained posteriorly its attachment to the vagina. Ordinarily the extent of the attachment of the bladder to the uterus becomes greatly increased in large uterine fibroids. In the specimen submitted supra-vaginal amputation of the uterus with the tumor could have been effected without separation of the bladder from any of its attachments. It is interesting to observe the condition of bilateral hydro-salpinx some six years after the menopause. The patient died with acute symptoms of vomiting and purging of dark fluids, containing probably blood, extravasated through the intestinal walls. At the autopsy no indications of perforation of the intestine were apparent. The patient was able to engage in active work a few days prior to death, and hence the double hydro-salpinx could not have occasioned pronounced symptoms.

which will be published in full in the *New York Medical Journal*.

In the Transactions of the Medical Society of the State of Pennsylvania for 1863, may be found an article headed, "Midwifery in the Country," in which are drawn statistics from 2387 consecutive cases of labor, to which are now added 649 cases, making in all 3036 cases with 3087 children.

Head presentations, (vertex) 3012.

Breech, including knees and face, 58.

Shoulder and arm, 5.

Face, 12.

Twins in 51 cases.

Ergot was used in 139 cases in first series. Forceps were used twenty-eight times in the first 2387 cases, and thirty-one times in the last 649 cases. Version was performed twice in the last series. One primipara was 52 years of age. Puerperal convulsions in eight cases, all recovered. There was a total of 190 cases in which the children were born before the doctor arrived, and in which the mothers did well under nature's management, and were saved the fright and suffering which, if Credé had been present, would have resulted from his fears of hemorrhage, his reach of hand into the vagina the moment after the child was born, and the grasping, squeezing and forcing down of the womb by the other hand on the tender, sore abdomen, to say nothing of having that heavy hand pressing on a tight bandage for two hours more, in accordance with regulation orders.

In the practice of this art I have not followed the requirements of the times. I have considered labor a natural process, and that my duty consisted in awaiting the action of the patient's forces: not setting them aside and myself usurping the duties which the natural efforts would have achieved without difficulty; but coming to my patient's aid only when her forces seemed inadequate to the performance of the duties.

I have learned that the forceps are used very often, many, many times oftener in proportion to number of cases than twenty years ago, and that this is done in the early part of the labor: not because nature is inadequate to the work, but because as the physician had

ON THE STATISTICS OF 3036 CASES OF LABOR, BY HIRAM CORSON, M. D.

Dr. Wm. Goodell read the paper,

never hurt *himself* by using the instrument and wished to get away speedily, as he had other patients who needed attention; and though the condition of the lying-in-woman would well have permitted him to visit his other patients and return in time to aid her, if she needed aid, still he would not do it, through fear that the child might be born in his absence, or some other doctor be called in his place. The graduate of a month can now use the forceps, and all the other swift-sure means of speedy delivery, without hurting his hands or spraining his back; of course, the sufferings and fate of the woman was of secondary importance.

Being anxious to learn all about the advances in midwifery, I attended the meeting of the American Gynecological Association, in Philadelphia, a few years ago. There I heard from the mouth of more than one eminent gynecologist—more greater than midwives—"Every year I use the forceps more frequently than before." There, too, I was amazed to learn, from the experience of these speakers, how numerous were the cases of lacerations of the cervix and perineum; so numerous, indeed, that when coupled with the fact that the advocates of frequent use of the forceps were teachers of midwifery and also eminent surgeons skillful to "repair" these lacerations, and that these repairs brought large remunerations to these surgeons. I was dazed; I knew not what to say; I could not believe it possible that the earnest gentlemen before me could have conspired to teach this rushing plan of delivery in order that lacerations should be produced, so that the business of repairing should be brisk and profitable. It was pleasant, a few months later, to hear that the eminent gynecologist, Dr. Goodell, attributed the great increase of lacerations to the use of the forceps, and earnestly denounced their indiscriminate employment.

In October, 1880, *The Boston Medical and Surgical Journal* contained an article by J. W. Elliott, M. D., on "Antiseptics in Gynecology," with full direction for their use in obstetrics to prevent puerperal fever by destroying poisonous germs which might be introduced by the doctor or nurse. (At the begin-

ning of labor the patient should have a hip-bath; the hair should be cut from the genitals, the vagina and vulva should be washed with soap and disinfected with carbolic acid.) "During labor every examination should be preceded by a vaginal injection of a three per cent. carbolic solution to prevent the examining finger carrying germs lodged at the vulva or in the vagina up to the uterus (which is about to be more or less lacerated.) After delivery, the uterus and vagina should be considered as a deep and important wound, which may heal by first intention, or in which the secretions may stagnate, become putrid and be absorbed." As I had never before heard of Dr. Elliott, I went on in my usual way, taking no razor to shave the parts, no syringe, no carbolic acid, but let nature go on with her work pleased to see how steadily and perfectly she accomplished it. Dr. Corson asks: Is labor a natural process? Are antiseptic solutions, when thrown into the uterus and vagina safe? and answers these questions from the standpoint of his own experience and by quotations from Albert H. Smith's lecture "On the Relation of Cleanliness to the Prevention of Puerperal Septicæmia;" Dr. W. O. Stillman's account of the precautions taken by Carl Braun, of Vienna, to prevent infection to the lying-in-woman; Dr. T. G. Thomas, of New York, a paper read before the New York Academy; Dr. Geo. J. Harrison, in reply to Dr. Thomas; and to papers by Fritsch and Kustner, and gives his own experience in his first labor case in 1827.

Dr. Corson next considers the forced delivery of the placenta, and claims the originality of the Credé method in its principal details for Professors James and Dewees. The latter saying that it had been long since recommended by Monsieur Dassé, of Paris. He criticizes the unnecessary severity of the latter part of the Credé method, and much prefers the directions given by Prof. Penrose, and then details his own method, which leaves more to natural powers, giving morphia if rigid contractions of the os occurs before the placenta comes away.

He recommends venesection to the extent of ten or twenty ounces to relax



a rigidly contracted os in the first stage of labor. If this is not immediately successful, he gives morphia internally. He uses ether to relax when pains are too severe.

Dr. Corson next considers the question of tying the cord. Should it be tied at all? How soon after birth should it be divided? What is gained by waiting until pulsation ceases in the cord? These are questions to which careful consideration has been given and which are fully answered. Dr. Corson does not use a binder; has not done so for twenty years. He does not think that it prevents relaxation of the uterus, but that it favors prolapse of that organ. He gives his own experience, and fortifies it by that of several physicians. He thinks the hasty extraction of the placenta, the compressing of the uterus by the hand, and the application of the binder with the avowed intention of preventing hemorrhage have a bad mental effect on the patient, and predispose to the very trouble we are seeking to avoid. He gives several instances of mental influences in stopping hemorrhage. He has never used hot water, vinegar, lemon or ice into the uterus for flooding, but has applied ice externally.

Puerperal convulsions, ten cases, all recovered; his treatment consists largely in free venesection, cold water poured over the head, and morphia internally. He recommends the hand-book of Dr. Ezra Mechner for the successful treatment of this malady. He would also avert convulsions by bleeding before labor to relieve headaches, if accompanied by congestion of the face. Of puerperal or septicæmic fever he knows nothing, having never seen it.

### Correspondence.

#### THE RUSH MONUMENT FUND.

*Editor Maryland Medical Journal.*

SIR:—The American Medical Association at the Washington meeting in 1884, authorized the appointment of a committee in each State to collect funds for erecting a monument at the National Capital to the illustrious physi-

cian, philosopher and patriot, *Dr. Benjamin Rush.*

It is intended to ask subscription (limited to one dollar each) from every physician and medical student in the United States, in order that the object above set forth may be accomplished. In every State and Territory this project has been enthusiastically received and subscriptions are rapidly increasing.

Drs. Frank Donaldson, Sr., No. 108 Park Avenue; J. R. Quinan, 1362 N. Gilmor street; C. H. Jones, 530 W. Fayette street; Wilmer Brinton, corner Forrest Place and Chase street; Spencer M. Free, corner Eutaw Place and McMechen street, in this city, and Dr. Chas. H. Ohr, of Cumberland, have consented to act with the undersigned as the sub committee for this State.

Subscriptions, accompanied by the name and address of the contributor, may be sent or handed to any of the above named, or to the undersigned.

All contributions will be formally acknowledged by the General Committee, of which Medical Director Albert L. Gibon, U. S. Navy, is chairman, and Dr. J. M. Toner Treasurer.

Very Truly Yours,

GEORGE H. ROHÉ,

*Secretary Rush Monument Committee.*  
BALTIMORE, 139 N. Calvert street.

#### SUPRA-VAGINAL HYSTERECTOMY.

WASHINGTON, D. C., June 5th, 1886.

*Editor Maryland Medical Journal.*

MY DEAR SIR:—I am induced by the report and discussion of Dr. Chunn's case of supra-vaginal hysterectomy, recently published in your JOURNAL, to very briefly report a somewhat similar case occurring in my practice last June.

My patient was white, however, aged 35, married, the mother of one child 8 years old, since which she had never been pregnant.

When I saw her she was as large as if nine months pregnant, and the case had been considered a pregnancy for about eight months.

In my report of the case to the Medical Society of the District of Columbia,

which was afterwards published in the *Journal of the American Medical Association*, December 5th, 1885, I stated that my diagnosis was ovarian tumor, with fluid too thick to permit the detection of fluctuation, or that it was calloid. I had no thought of malignancy. The patient was in good health, had good color, appetite and digestion, slept well, was comparatively free from pains, had lost no flesh, and barring her size and the weight of the load she was carrying about in her abdomen, and the pressure it made on the surrounding organs she called herself a well woman.

She was, however, anxious for its removal, as it was enlarging rapidly, and as the weather was then very hot, the first week in October, 1885, was set for the operation. In the meantime she was examined by several physicians and a variety of opinions was expressed. In September I requested a distinguished gynecological specialist, who had operated frequently and who had witnessed numerous operations abroad, to examine her with me. He did so and was so positive in his opinion that "the tumor was a solid fibroid and as it was growing very rapidly, the proper operation was" he said, "the removal of the uterine appendages, etc.," that I explained the "situation" to the patient and her husband and Tait's operation was agreed to.

Mrs. W. took a private ward in the Providence Hospital and I began the operation on October 5th, with the intention of simply removing the ovaries and tubes.

When the abdomen was opened instead of a solid fibroid I found a tense cyst. I tapped it and withdrew eight pints of thin coffee colored fluid. There were no anterior adhesions, but the cyst was so adherent upon its entire posterior surface that more than an hour was consumed in liberation and bringing the sac outside of the abdominal opening. "It was then found that the attachments to the uterus were so intimate that they could not be separated without producing great hæmorrhage, and the removal of the uterus was finally determined upon." "A clamp was therefore applied at about the internal os and uterus and

tumor was cut away with the thermo-cautery. The pedicle was secured in the lower angle of the wound, and the incision in the abdominal wall was closed with light silk sutures, after cleaning out the pelvic and abdominal cavities and putting in a glass drainage tube above the pedicle."

I had very little expectation that the lady would recover and so informed her husband. She rallied well, however, and spent a good night and never had a bad symptom of any kind. Her pulse never rose above 108, or her temperature above 101°. She made a perfect recovery and left the hospital at the end of her fifth week. She frequently made the remark that she had suffered more from a burn on her heel made by a bottle of hot water placed too near her foot by the nurse, than from anything connected with the operation.

I took the specimen to Dr. Billings at the Army Medical Museum and the following is the report of the microscopist.

War department, Surgeon-General's Office, Army Medical Museum,

WASHINGTON, D. C., Oct. 27, 1885.

J. Taber Johnson, M. D.,

DEAR DOCTOR:—The abdominal tumor sent here for examination proves to be a cystic adeno-carcinoma of the ovary. \* \* \* Besides the cystic formation, there is a decided cancerous infiltration which occurs in patches, and the appearance of a cylindrical epithelioma. The uterus is also infiltrated with the carcinoma, but has not undergone degeneration.

Respectfully, etc.,

W. M. GRAY, M.D.,

Miscroscopist.

This patient did well for six months when the cancer returned in the vaginal portion of the cervix and she died on May 16th, 1886, eight months and twenty-one days from the date of the operation. Had I suspected that the tumor was cancerous at the time I operated, I would have removed the entire uterus and perhaps given the patient a better chance for her life.

Respectfully Yours,

JOS. TABER JOHNSON.



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BALTIMORE, JUNE 12, 1886.

Editorial.

ALEXANDER'S OPERATION OF SHORTENING THE ROUND LIGAMENTS.—As far back as 1840 Alquié, a French surgeon, proposed and discussed the operation of shortening the round ligaments, but his proposition met with such unfavorable notice that it was not carried into effect on living subjects. Forty-one years subsequent to this period, in December, 1881, Dr. William Alexander, of England, successfully operated on a case of prolapsus uteri by pulling out and shortening the round ligaments. The results of this operation were successful, and demonstrated the fact that by drawing out the round ligaments through the external abdominal rings it is possible to lift the uterus and broad ligaments upwards and forwards and by attachment to hold this organ in its proper position. When the uterus is movable backward displacements and prolapse can thus be corrected. Since Dr. Alexander first performed the operation, which bears his name, it has been done in over one hundred and forty cases by some twenty-one operators. Three deaths, as the result of operation, have been reported, one of which was in a case of Dr. Alexander. The operation has been performed forty times by Dr. Alexander, thirty-six times by Dr. Imlach, and thirteen times by Dr. Burton, making a total of eighty-nine cases with good results in eighty-six cases. In this country Dr. W. H. Polk, of New York, has operated more

frequently than any other surgeon. He reports ten cases with ten good results. Dr. Mundé, of New York, has operated six times with only two good results, this operator having failed to find the ligaments in three cases. Dr. F. B. Harrington, of Boston, reports two cases with results yet questionable, in view of the very recent date of the operations, but with a good opinion of the operation. In our own city, Dr. R. Winslow has operated twice with good results in each case. The most unfavorable report of the operation has been made by Mr. Lawson Tait, who has operated once with a bad result, his patient having nearly died. Mr. Tait's opinion of the operation is accordingly "bad." Dr. W. A. Duncan reports four cases with results bad in three and doubtful in one. His opinion of the operation is expressed as "doubtful."

Taking the experience of Drs. Alexander, Imlach, Burton and Polk we find a total of ninety-three operations with only three bad results. Some of these cases have stood the test for three or four years. Dr. Alexander's opinion of the operation is that it is a delicate one, and not devoid of difficulties and dangers. The chief difficulty encountered is in finding the ligaments and in drawing them through the inguinal canal. This difficulty was experienced only once by Dr. Alexander, but Dr. Imlach has not failed to find it in the thirty-six cases in which he has operated. Dr. Mundé encountered this difficulty in three out of six cases.

The results thus far achieved certainly tend to prove that this operation is almost devoid of danger, and that its results are sufficiently good in the vast majority of cases to justify its employment in properly selected cases. There are certain conditions of backward displacements and of prolapse of the uterus which undoubtedly can only be corrected by shortening the ligaments, cases in which pessaries cannot be worn in consequence of the sensitive condition of the parts. A perfectly movable uterus is a prerequisite to success, since an organ bound by adhesions cannot be lifted or held in position by any amount of trac-

tion on the ligaments. The opponents of this operation have argued that little is to be gained from the procedure from the fact that the round ligaments are but slender cords, and even though shortened, will sooner or later relax and allow the uterus to return to its former position. This argument can only be answered by experience and time, and as only some four or five years have elapsed since the procedure was first instituted a *sub judice* opinion upon this point is proper. But even grant that an exemption is obtained for three, four or five years, is not this relief a justification for a procedure attended with comparatively trivial consequences? Another fact which has been encountered by those who write, rather than practice the operation, is the dreaded "fear of the peritoneum." None of the operators seem to have encountered this membrane in their efforts to draw out the ligaments and we much doubt whether a grave source of danger is met with even were this membrane encroached upon. Upon the whole the operation commends itself for its reasonable, safe and practical results.

**LIGATURE OF THE LARGER ARTERIES IN THEIR CONTINUITY.**—At a recent meeting of the Royal Medical and Chirurgical Society (*London Lancet*, May 15 1886, p. 922) a very instructive paper having the foregoing title was communicated by Mr. Ballance and Mr. W. Edmonds. The object of the paper was to show that in the ligature of a large artery in its continuity it was neither necessary nor advisable to tie the ligature so tight as to rupture the coats of the vessel, but that it was necessary that the lumen of the vessel should be completely or almost completely obliterated. The conclusions reached were based upon experiments which were made by the permission of Professor Birch-Hirschfeld at Leipzig. Nineteen carotid arteries of sheep and horses were ligatured, seven with catgut and others with kangaroo tendon. The results in each case were given. The animals were killed and the vessels removed from nine hours to seventy-three days after

ligature. As a result of these experiments the authors recommended for the operation of ligation in continuity, (1) aseptic precautions; (2) the small round absorbable ligature; (3) the maintenance of the integrity of the arterial wall. The authors exhibited macroscopic and microscopic preparations, and also drawings, showing that the inner coats, even where included in the ligature, were alive and apparently of unimpaired vitality, and that, although the tunics were unruptured, a plastic effusion had taken place, which in the arteries removed latest was developing into connective tissue, permanently occluding the vessel. With respect to the ligatures it was observed that leucocytes were thrown around them and had gradually caused their absorption. In the case of kangaroo tendon, the absorption took place only from the surface; but with catgut the leucocytes insinuated themselves along the crevices formed by the twisting of the gut, and the ligature became absorbed more rapidly. The durability of catgut seemed to vary in specimens. The authors thought that in wounds that healed by first intention, catgut held for about a month and kangaroo tendon for two.

In the discussion which followed the reading of this paper the views of the speakers did not coincide. The opinion was expressed by Mr. Barwell that it was especially undesirable to rupture the internal coats, but this fact was questioned by Mr. Savory and Mr. Holmes, both of whom doubted the possibility of obtaining the desired end by the method recommended when applied to the human subject. Mr. Savory claimed that the statements contained in the paper were *ex parte*. Experimental investigations, he thought, tended to show that the arterial system of animals differed very much from that of man; it was much more difficult to excite the septic process in animals. Mr. Holmes said he was not willing to trust experiments on animals in guiding him as to what to do in the human subject. The practical question raised by the two speakers last named, as to



whether we can argue from the arteries of sheep and horses to those of human beings must for the present remain undecided. Theoretically the position advanced by the authors seems possible. The point raised in respect to the inadvisability of not rupturing the internal coats for fear of opening channels for septic absorption and with a view of preventing damage from ulceration and subsequent danger from hæmorrhage is one which the surgeon must feel has a direct bearing upon surgical practice.

**THE RUSH MONUMENT.**—We desire to call the attention of our readers to the letter of Dr. Rohé which is published in another column. The proposed monument in commemoration of the eminent services of Dr. Rush to humanity, to science, and to his country is an appropriate recognition of one of the most notable characters of revolutionary times. The American profession will honor itself by making the memorial worthy of its distinguished subject. We trust that Maryland physicians will respond promptly and liberally to the appeal of the committee.

**ON THE TREATMENT OF SIMPLE GANGLION.**—Amongst the minor surgical affections which fall under the notice of the general practitioner, and demand his attention, simple ganglion is one of the most frequent. Every one readily recognizes the circumscribed swelling, usually situated upon the dorsal aspect of the wrist in connection with the extensor tendons, but not unfrequently found upon the anterior carpal surface of the forearm, and occasionally in other locations, as the dorsum of the foot. These little tumors rarely exceed the size of a hickory nut, and, according to circumstances, are soft and fluctuating or hard and firm from the deposition of fibrin upon the cyst wall. They usually appear as the result of a sudden twist of the wrist, and often are found upon laundresses who have strained their wrists whilst wringing clothes. The condition is due to a rupture of the sheath of a tendon, somewhat after the manner of an aneurism, or the gradual

pouching out of the sheath until a sac is formed; gradually the mouth of the sac is closed in many cases and a distinct cyst is formed. The contents of the cyst are variable, being in some cases a simple glairy synovial secretion, in others a thick colloid or jelly-like matter, and in others still containing, in addition, bodies resembling melon seeds, or grains of rice; these bodies being formed from the synovial fringes of the sheath. Sometimes, when the sac is thin and the fluid simple synovia, the ganglion may be made to disappear by painting with iodine, and with pressure, but this simple treatment usually fails, and the attempt is generally made to rupture the sac and allow the escape of its contents into the surrounding tissues. This often succeeds, and should always be employed in preference to any more serious procedure. The best method of effecting a subcutaneous rupture is by pressing with one or both thumbs; a more violent rupture may be effected by striking the bent wrist with a book or other hard body, but we venture to state that such a method is rude, painful and unsurgical, and is liable to be followed by unpleasant effects. When the cyst does not rupture upon thumb pressure, its subcutaneous puncture, with a narrow tenotome, and cutting its walls in numerous places, whereby its contents are scattered, and the sac destroyed, offers the best prospect of cure. After all these methods the hand should be fixed and pressure made directly upon the collapsed sac. When a recurrence takes place, in spite of these methods, some more radical operation must be undertaken. Some surgeons recommend the injection of iodine, as in hydrocele, but it does not seem to us to be a safe method of treatment. Agnew relies largely upon the use of a seton, which is also lauded by Bryant, but with a caution in regard to its danger. Excision of the ganglion has been performed in a number of cases, and in pre-antiseptic days this method was not unfrequently followed by dangerous inflammation of the tendons and their sheaths, so that it is usually condemned by surgical authors. As antiseptic methods render operations

safe which were formerly dangerous, so is it in regard to incising and excising these tumors. This open incision should not be undertaken until other means have failed, but with proper precautions a cure may be obtained in this manner, with very little danger either to the function of the part or to the life of the patient. A modification of simple incision is the antiseptic opening of the sac, and the scraping of its walls with a sharp spoon. This method is perhaps the most desirable of any of the more serious plans of treatment. Sometime since a girl presented herself for treatment of a ganglion situated upon the dorsal aspect of the wrist. Digital pressure was tried, but the cyst walls were too thick and could not be ruptured in this way. Subcutaneous incision of the sac was performed twice unsuccessfully, that is, the swelling soon reappeared. As the tumor was both ugly and painful, and interfered with the functions of the wrist, a free opening was made and the sac entirely cut away, the wound was treated antiseptically and the hand fixed upon a splint. No further trouble was experienced, the parts remaining uninflamed and the functions of the wrist and hand were unimpaired. This plan of treatment ought not, however, to be undertaken until other means have failed, and then only under the rigid employment of antiseptics.

An interesting discussion upon the treatment of ganglion of the wrist, occurring at the New York Surgical Society, is reported in the *Medical News*, March 21, 1885.

### Miscellany.

INSPIRATION OF COLD AIR IN FEVER.—The effect of breathing cold air has been made trial of in St. Petersburg by Dr. Ivan Voitekevich on a number of patients suffering from various pyrexial diseases, enteric fever, croupous pneumonia, pleurisy, &c. His method of proceeding was to take the pulse and respiration, and also to note the temperature in the rectum, axilla, and on the surface of the chest, immediately afterwards to

apply to the patient's face a mouthpiece connected with a tube communicating with the external cold air, directing the patient to inspire deeply. The mouthpiece was removed during expiration and replaced for each inspiration. The "sittings" were usually continued for from twenty to thirty minutes, but were stopped at once in cases where the patients seemed exhausted or faint, which, however, very rarely happened. The "sittings" were usually repeated morning and evening for several consecutive days. The temperature of the ward was always noticed, and was usually between 60° and 70° F. The external temperature, which was that of the inspired air, was, as a rule, about 20° F. lower. After the "sitting" the observations on the pulse, respirations, and temperature of the patient were repeated both immediately and after the lapse of one and two hours. The results attained showed that the temperature was lowered but slightly and for a very short time, but that a considerable diminution was produced in the frequency of both pulse and respiration. The patients, too, felt better and slept longer, but this was but temporary. The cold air appeared decidedly to lessen the bronchial catarrh from which they suffered. No evil effects were observed, but, on the contrary, the cold air treatment appeared to act in a beneficial manner.—*Lancet*, May 8, 1886.

THE TREATMENT OF RETENTION OF URINE.—The skilful use of the catheter in a large proportion of cases of retention of urine associated with organic stricture is followed by immediate relief, but the operation is often prolonged, and always very painful, unless performed under the influence of an anæsthetic. Sometimes the urethra is lacerated, and, when this accident occurs, irritation or fever are excited, which are soon followed by increased contraction of the strictured part of the canal. Cases of retention in which it is found impossible to introduce into the bladder any kind of instrument are of rare occurrence at the present day; but when such cases are met with, provided the patient's condi-



tion demands immediate relief, the bladder should be aspirated at once above the pubes.

Dr. J. Ward Cozzens suggests in the *Med. Press*, March 31, 1886, a trial of the capillary catheter, which he has now used successfully in many cases of retention with great satisfaction. The operation is practically painless, and requires no anæsthetic, while the flexible capillary catheter, even if it fails to do good, can really do no harm. The form which he uses is a compound instrument, consisting of a filiform bougie and a fine catheter, very carefully prepared with woven web and gum elastic, and possessing great flexibility and toughness, together with a smooth and highly-polished surface. His method is to first inject the urethra with warm oil, and gently pass the catheter down to the stricture. As soon as its progress is stopped, it must be rotated between the thumb and finger, then withdrawn two or three inches, and twisted down again upon the obstruction. During the repetition of these procedures the little instrument often readily passes into the bladder. After the operation is over the instrument may be retained for a few days, or it can be removed and introduced in a day or two, and employed as a guide for a tubulated catheter.—*Ther. Gaz.*

CHANGES IN THE PROFESSION.—The transition from medicine to science is most easy, and a large proportion of our eminent scientists have been brought up as medical men, and some have practised as such. As instances may be mentioned, Professor Huxley, Sir Joseph Hooker, Dr. Bayley Balfour, Dr. Odling, Professor Crum Brown, Professor Martin Duncan, and Professor Sanderson. Literature furnishes many similar examples. The present editor of one of the most popular of our monthly magazines is a medical man. Divinity, too, has proved to many of our profession a more attractive study than medicine, and not a few doctors have ceased to be practitioners in order to become ministers of religion. Law has not attracted so many votaries; still, it has lured some from clinical pursuits. At least one

medical man has lived to be a judge, and an eminent queen's counsel now living was not only brought up to the medical profession, but actually practised it for twenty years, attaining some repute as an obstetrician. It is interesting to note that he has educated his son for his adopted, not for his original profession. I have known an instance of a converse change. A young man who had been brought up as a solicitor tired of law and forsook it for medicine. I have also heard a lawyer express the wish that he had been a doctor. Many doctors in this country are tempted—on financial grounds—to wish the opposite. Law offers rewards such as medicine cannot, and is the pathway to honors denied to the sister profession.—*London Cor. Med. Record.*

ACTINOMYCOSIS IN THE HUMAN SUBJECT.—An example of this interesting and rare disease is reported to have been met with at the Montreal General Hospital recently. The patient, a young female adult, was thought to have died of pithisis, but the investigations of the pathologist revealed the true nature of the malady. This case is of special interest, as few, if any, authenticated cases have been as yet recorded in America. It is down for consideration at the next meeting of the Medico-Chirurgical Society.—*Medical Record.*

IODIDE OF POTASSIUM IN SPASMODIC ASTHMA.—Dr. J. Ormrod publishes in the *Practitioner* (April 10, 1886) a tabular analysis of the results obtained in thirty-six cases of asthma treated with iodide of potassium. All of the cases displayed, though with varying severity, the cardinal symptoms of the disease,—that is, difficulty of breathing coming on suddenly, usually in the early morning during sleep, and passing off after a time, so as to leave the patient comparatively well, but recurring usually in a regular fashion at regular intervals. The iodide was given alone, or, if in combination, only after the effect of the uncombined drug had been tried, and it proved a failure only in nine cases out of thirty-six,—that is, in twenty

five per cent., while its good effects were not limited to the uncomplicated cases. Five or ten grains three times a day seemed to suit best in most cases, but in some a larger or smaller dose did better. In some, again, an increase of the dose did good for a time, but the effects seemed to wear off. In confirmed cases the drug can hardly be claimed to be curative, though it will in many relieve attacks, which, however are apt to return when the use of the drug is stopped.—*Ther. Gazette*, May 15, 1886.

PILLS FOR HABITUAL CONSTIPATION.—Duchesne ("Nouveaux remèdes," April 15, 1886) credits the following formula to Huchard:

Resin of podophyllum, }  
 Soap } each  $4\frac{1}{2}$  grains.  
 Extract of hyoseyamus, }

Divide into ten pills. To increase their efficiency, a grain and a half of extract of rhubarb may be added to each pill, or the same quantity of euonymin; or, if the constipation depends on intestinal atony, from one eighth to one fifteenth of a grain of extract of nuxvomica.—*N. Y. Medical Journal*.

EXTRAORDINARY CÆSAREAN OPERATION.—*La Gazzetta degli Ospitali* of the 2nd instant reports the convalescence of a patient who performed the Cæsarean operation on herself on March 28th ult. These are the facts: A peasant woman of Viterbo, aged twenty-three, illegitimately pregnant at full term, at dawn on March 28th last, with a common kitchen knife (*con un coltellaccio da cucina*) opened her own abdomen on the right side. The wound, five inches in extent, was oblique from within outwards and from above downwards. The woman then opened the uterus in the same direction, and endeavored to extract the foetus. As this was at full term it could not be readily removed. The mother first drew out an arm and cut it off. To still further reduce the bulk she amputated the head, and then completely emptied the womb, extracting the placenta. She bound a broad bandage very tightly round her body, hid the foetus in a straw mattress, dressed her-

self, attended to some domestic duties, and on a cart went into the city of Viterbo to show her sister a cloth bathed with blood, as a menstrual proof of her not being pregnant. On returning home, having walked about for five hours, she vomited and fainted, and the parents called in Drs. Serpieri and Baliva. Thirteen hours had elapsed from the infliction of the wound, and through it the intestines had been protruding for six hours. The medical attendant having satisfied themselves of the complete reduction of the emptied uterus, performed abdominal toilette as well as was practicable, replaced the viscera, introduced a drainage-tube, and sutured the wound. The evening temperature was  $37.7^{\circ}$ ; lochia natural per *vias naturales*. The woman stated positively that she had no accomplices. No unfavorable symptoms supervened. The deep wound healed, and was only superficial on the 15th of April, the 18th day after the self-performed Cæsarean operation. The countrywoman of Mutius Scaevola has proved that the fearless bravery of the Romans lives.—*Lancet*, May 8, 1886.

ARTHROTOMY FOR LOOSE BODIES IN JOINTS. — M. Kirmisson recently presented to the Société de Chirurgie two cases of loose bodies in the knee-joint for which arthrotomy had been successfully performed. He assented to the view that some of these bodies are truly traumatic in nature, being broken off from articular cartilages by violence; while others, the greater number, are pathological in origin. The arrangement of the cells in the cartilage usually allows it to be determined whether a given "loose body" is traumatic or pathological in origin, but in some cases this point cannot be cleared up. M. Kirmisson suggested that the use of a drainage-tube was not necessary after arthrotomy for the removal of such loose bodies and he also advocated including the synovial membrane in the sutures. Both these points excited considerable discussion. Some surgeons were strongly in favor of abandoning the drain; others argued that it was harmless, and might



prevent serious mischief. Cases can be cited in favor of each view. Where the arthrotomy is very simple, and there is no synovial effusion, a drain appears to be unnecessary, and may be dispensed with; but if the operation be prolonged, complicated, and attended with much manipulation of the synovial membrane, or if the joint be the seat of a chronic effusion, it is much safer to insert a drain. Should a drain not be used, it is better not to insert sutures; any exudations then have a free exit from the wound; while if the wound is closed tension may be excited. The best form of suture would be a "buried suture" of the synovial membrane preliminary to the closure of the superficial wound.—*Lancet*, May 8th, 1886.

**FISSURE OF THE ANUS.**—In the *British Medical Journal*, February 27, A. D. Macgregor proposes a novel mode of treatment of anal fissure, no cutting or even stretching of the sphincter being done. He orders a full dose of castor oil and rhubarb; when this has operated, the bowel is washed out with an enema containing Condyl's fluid. This done the speculum is passed and the fissure is painted with a solution of chloride of zinc, twenty grains to the ounce. A piece of lint with boric ointment is used as a dressing; the bowels are held in check by opium, liquid food only being allowed. One application of the chloride of zinc is found to be enough. Only a little smarting and uneasiness is caused thereby. The fissure is effectively purified and the reparative process stimulated.

**THE INCOMPATIBILITY OF CALOMEL AND BROMIDE OF POTASSIUM.**—Vigier (*Gaz. hebdom. de méd. et de chir.*, May 7, 1886) remarks that calomel is decomposed on the addition of potassium bromide, although more slowly than when the iodide is added. Nobody, he thinks, would give the two drugs within five or six hours of each other, but it might happen, for example, in a case of infantile convulsions, that, two practitioners being called in quick succession, the second one might order one of these

drugs after the other had been given by the advice of the first one. He gives the caution, therefore, that in such cases their incompatibility should be borne in mind.—*N. Y. Med. Jour.*

**M. PASTEUR.**—The Paris correspondent of the *London Lancet* writes, "I have had an opportunity of revisiting M. Pasteur's laboratory in the Rue d'Ulm, under the following circumstances:—A young lady, a daughter of Mr. Morisini, the well-known banker of New York who was said to have been bitten by a mad dog, was brought to Paris to undergo M. Pasteur's anti-rabic treatment. The young lady was accompanied by her parents and by Dr. Bulkley, the celebrated dermatologist of New York, who asked me to introduce him to M. Pasteur. This I gladly consented to do, and on Monday morning, the 3rd inst., the day after their arrival in Paris, the young lady was inoculated with the anti-rabic fluid. But before the operation was performed M. Pasteur, as is his wont, inquired particularly into the circumstances of the case. Dr. Bulkley furnished the necessary information and produced a certificate from a well-known veterinary surgeon testifying to the dog having been really affected with rabies. The young lady was bitten on April 14, on the space between the root of the nose and the inner angle of the right eye, which was soon after freely cauterised with the nitrate silver by Dr. Bulkley. Nineteen days had therefore elapsed between the accident and the inoculation. During my visit at the laboratory it struck me that the hydrophobia scare had not lessened, for the place was crowded with applicants from all parts of the world. M. Pasteur is as zealous as ever, and I learn that the Emperor of Brazil has conferred on the eminent biologist the Order of the Rose."

**VANILLA POISONING.**—In connection with about twenty cases which have occurred lately where persons have been suddenly siezed with severe attacks of vomiting and purging shortly after having partaken of vanilla cream pies and cakes made by a certain baker in

Boston, any possible explanation of the cause is of interest.

In these, as in the numerous other cases reported in the *London Pharmaceutical Journal*, of April 1874, the presence of irritant metallic poisons and of ptomaines has been searched for in vain. In the Berlin cases only certain individual foods had proved to be poisonous. In a number of the *Repertoire de Pharmacie* for 1880, M. Jaillet in an article upon the cultivation and preparation of vanilla says, that in the Island of Bourbon the *Jatropha curcas*, or physic-nut tree, is by preference grown as a support for the vanilla vine to run upon, because of its easy, rapid growth, and abundant milky juice well adapted to the nutrition of the vine.

It has been thought by some that this fact might explain the poisonous effect of some vanilla, supposing that the acrid sap of the *jatropha* had been absorbed by the vanilla vine. Under what circumstances, however, this absorption takes place is not explained, nor why it is of but exceptional occurrence.

There is this curious circumstance concerning all hitherto reported cases of vanilla poisoning, that it has resulted only with articles of food which were not consumed while hot, but were either of the natural temperature or else unnaturally cooled. On the other hand, vanilla is extensively used in the preparation of chocolate and teas as well as sauces and other articles which are taken while hot; but when thus used it has never been followed by symptoms of poisoning so far as reported. Hence that manner of use, at least, would seem to be always safe, and the fact would rather support the idea that the trouble results from some product of decomposition.—*Boston Med. and Surg Journal*.

### Medical Items.

The "Kirmes" recently given in New York City, for the benefit of The Skin and Cancer Hospital netted between \$5000 and \$8000.

A Cremation Association has just been incorporated in Detroit, Mich., with Dr. Jas. F. Noyes as President, and Dr. Hugo Erichson as Vice-President.

The Long Island College Hospital graduated forty-nine students on June 2nd.

A graduate of the College of Physicians and Surgeons, of considerable experience, desires the change of a practice for one or more months during Summer. Address Beta, Monkton, Baltimore County, Md.

It is announced that the Alumni of Jefferson Medical College, Philadelphia, will tender a complimentary dinner to Professor W. H. Pancoast, on the 17th inst., on his retiring from the chair of anatomy in the college.

Dr. Oliver Wendell Holmes has received a handsome ovation in England. He was entertained at the St. George's Club, in London, on the evening of May 24th, by a distinguished company of American and English gentlemen, including United States Minister Phelps, the Dukes of Argyll, Westminster and Manchester, Lord Napier and others.

The French Government has been asked by Pasteur for a subsidy of 2,000,000 francs for the establishment of a hospital, and for 50,000 francs a year to operate it. It is said that the authorities are in favor of giving him at least the latter grant. The Académie de Médecine has already voted a grant of 10,000 francs to his institute.—*Med. Record*.

Mr. Lawson Tait has recently (*British Medical Journal*, May 15th) reported 139 consecutive ovariectomies performed in 1885, without a death and without refusing to operate in a single case. Mr. Tait does not use antiseptics and does not believe in germs. He simply washes out the abdominal cavity with blood-warm water, which is allowed to flow until the water comes out clear. Mr. Tait believes in operating early for the removal of tumors and he makes the incision in the abdomen as short as possible. His success is the result of a large experience, and of a remarkable skill acquired by a faithful observation of the conditions met with in this special work. This success has completely destroyed Mr. Tait's fear of the peritoneum and "has," he says, "justified our opening the sacred sac very much as we open our pockets."

The late President of the American Medical Association in his annual address accused the *New York Medical Journal* and the *American Practitioner and News*, of Louisville, Ky., of having antagonized the Association, and suggested that these journals had better change their editors "if they wish to retain the patronage of the members of the Association." A correspondent to the *Weekly Medical Review*, a devoted champion of the Association, characterized this statement as nothing less than a threatened "boycott," and has warmly resented the idea that professional journals should suffer in the respect of their readers because they might not be found trimming to every passing breeze of opinion. We rather hold to the opinion that those Journals which antagonized the Association in its revolutionary course have nothing to fear from President Brodie's threatened "boycott."



## Original Articles.

## CONSTIPATION.\*

BY ARTHUR V. MEIGS, M.D.,

Physician to the Pennsylvania and to the Children's Hospitals.

The title I have selected is one which includes a much wider field than I shall at all be able or intend to cover within the narrow scope of my paper. My object is merely to give a brief account of such cases as have come under my notice and to draw what inferences I am able with regard to the lessons to be learned from their study.

CASE I.—A woman now eighty-three years of age had been constipated for many years past, and is in the habit of taking almost daily a pill which consists of ext. belladonnæ gr.  $\frac{1}{2}$ , ext. nucis vomic. gr.  $\frac{1}{2}$ , aloes gr.  $\frac{1}{2}$ , and rhubarb gr. j. She has sphincterismus and some slight narrowing of the anal orifice, with hypertrophy of the spineter and slight retraction upward of the anus. There is nothing this woman dreads more than constipation for some years ago she had an attack, when the rectum became so full that the contents had to be removed mechanically. During the past four or five years she has been subject to attack of chills, followed by nausea and vomiting. These attacks occurred every six or eight weeks, or sometimes at longer intervals, and prostrated her much, confining her to bed, usually for two or three days. They were attributed, by one of the physicians who saw her to malaria and treated accordingly. Last winter, after long puzzling (for I have known this patient professionally for eleven years) as to the possible causes of these attacks, it struck me that they might be due to digestive disturbance, as they were so invariably accompanied by nausea and vomiting, and because when she had an attack she would invariably complain that her bowels were not properly opened, and this although there had been a movement every day. I invariably gave some aperient medi-

cine, usually merely an increased number of the pills that have been already mentioned. In the early winter of 1885 she had one of these attacks, and after four or five days when she had taken the aperient pills until she had three or four movements daily, which her maid declared were large and loose, she still complained so bitterly of a sensation as if there was something in the rectum, that I made a digital examination. My surprise was great to find that the rectum was full of feces of the consistence of soft brick clay which it was quite impossible to remove with the finger as it merely passed through the mass in any direction. It was equally plain that enemata would not effect the purpose, for she had had as many as four or five on each of the past two or three days, and although each one would bring away some little feces the discomfort still continued as great as ever. I accordingly directed that she should be given one of the pills four times a day until she had five or six movements each day, and they had ceased to be at all pasty and had become watery. This entirely removed the trouble and the amount of the movements was very large. This convinced me that the cause of the attacks was a gradual accumulation of fecal matter in the intestine, probably in the sacculi, notwithstanding the fact that previously there had been large and natural movements almost every day; and, consequently, that every six or eight weeks a quantity of this material larger than her own unaided forces were competent to get rid of, descended into the rectum. Acting upon this belief, I directed that on two days of every second week she should take three of the pills, hoping thus to aid nature in getting rid of any accumulation that might take place. This plan being followed out, she had no more attacks for about six months, and the only apparent effect produced by the pills was that on the days they were taken there would be positively two movements, although generally only one, and that these movements were very large. During the summer she was in the country and consequently was attended by

\*Read before the College of Physicians of Philadelphia, May 5, 1886.

another physician, I was sent for at midsummer to find that she had been sick a-week and was much prostrated, and had nausea and *constant diarrhoea*. Suspecting that the old trouble might be the cause of the attack I made a digital examination of the rectum to find my suspicion correct, for it was again full of feces. After much difficulty, for it was hard to bring the physician in the country to see the necessity for giving large doses of aperient medicine to cure a diarrhoea, she was finally relieved. It was only, however, after I had removed what I could of the mass with my finger, had given numerous injections, and she had taken four times daily for four or five days a pill consisting of ext. belladonnæ gr.  $\frac{1}{4}$ , ext. nucis vomic. gr.  $\frac{1}{4}$ , ext. colocynth. co. grs. ij.

CASE II.—In the autumn of 1881, I attended an unmarried woman of about sixty years of age, with a bad cold which finally took the form of mild bronchitis, but did not confine her to bed. She was a tall, thin woman, and had all her life been frail and delicate. After about three weeks, when the bronchitis seemed nearly well, and I was beginning to think that in a few days more she would have entirely recovered, she suddenly and without apparent cause began to get weaker, would occasionally vomit, and lost all desire for food. Soon she was confined to bed, and as she was constipated I ordered a seidlitz powder, which had had about the usual effect, producing one or two watery movements. This condition continued for a week or two, the woman becoming all the time weaker, vomiting once or twice a day, suffering with almost constant nausea, and having the bowels moved when some medicine was given. The constipation was not at all a marked feature in the case, for a movement could always be provoked by giving a seidlitz powder or half an ounce of castor oil, which was given once or twice, and the movements induced by these medicines did not present any unusual features, being, as is generally the case, loose, and somewhat watery. Examination of the abdomen

showed it to be flat, but as there seemed to be some slight induration along the line of the colon a suspicion of the true cause of the symptoms at last struck me and I ordered a mild pill consisting of ext. belladonnæ gr.  $\frac{1}{4}$ , ext. nucis vomic. gr.  $\frac{1}{4}$ , aloes  $\frac{1}{4}$ , rhub.  $\frac{1}{4}$ , to be taken three times a day. After she had taken this pill for six or seven days I was shown one morning four enormous passages. These had been passed within a short time of each other and consisted entirely of formed matter which must have been between an inch and a half and two inches in diameter, and perhaps two or three feet in length. From this time her recovery was rapid and very soon was complete.

CASE III.—A woman about seventy-five years of age, who has been habitually constipated as long as she can recollect, and has for a long time had sphincterismus and consequent narrowing of the anal outlet, with some retraction upward of the anus, had in the winter of 1884-85 an attack of constipation for which she took a great deal of purgative medicine in the course of a week, without ridding herself of a sensation as though there was an irritating foreign body in the rectum. By the end of the week she had hemorrhoids, which were very tense and painful, and the offending body came frequently to the anus, but her utmost efforts failed to rid her of it. Even when she tried to remove it with the finger, it slipped back into the pouch of the rectum, eluding her grasp. Upon digital examination a mass was felt in the rectum, and by hooking the finger around it it was removed with some slight difficulty and with great suffering on the part of the patient. This mass was from an inch and a half to an inch and three-quarters in diameter and nearly circular, and, therefore, not so large but that it could easily have been extruded from an anus of natural size. It was so hard that no effort enabled me to break it with my finger, and was yellowish-white and incrustated with a chalky substance, so that in both appearance and consistence it much resembled a freshly passed gall-stone.



CASE IV.—A young woman of about twenty-two, took, at the recommendation of a friend, a tablespoonful of sulphur on two successive days for dysmenorrhœa, with which she suffered. I was sent for the next day, as she had diarrhœa which did not amend. From this time, for between two or three weeks, she had constant fever, the maximum temperature being 102° F., with some sallowness of the skin, pain in the abdomen, with tenderness in the left iliac fossa and complete loss of appetite. The movements of the bowels were thin and watery, and the case presented many of the features of a milk attack of typhoid fever; but Dr. Da Costa, who saw the patient with me, and myself agreed that it was not so. The case was in so many respects like typhoid fever that the differential diagnosis was very difficult. However, the tongue was not characteristic, there was little or no tympany, no spots or sudamina, and no hebetude or epistaxis, and the abdominal tenderness upon pressure, which was very marked, was in the left and not in the right iliac fossa. On the other hand, the conditions were in many indescribable ways like typhoid fever, and there was diarrhœa with continued fever lasting for more than two weeks and no discoverable cause for the symptoms. At the end of about two weeks and a half I was shown a brownish watery passage which had at the bottom a little gritty material almost like red gravel. This at once led to a suspicion that there must be some obstruction, and it was determined to give small doses of aperient medicine, but before this was carried into effect the patient passed two masses which were almost circular and about an inch and a half or an inch and three-quarters in diameter, and from this time there was no more fever. A few doses of a mild aperient brought away several more fecal masses and the tenderness in the left iliac fossa was relieved; the patient speedily recovered her appetite, and convalesced without further drawback.

CASE V.—When I took charge of the wards of the Pennsylvania Hospital on August 1 1879, I found there a woman

fifty-eight years of age suffering with jaundice, great enlargement of the liver and of the abdomen generally, and constant fever. There were exacerbations of the fever about once a week, during which the temperature would run up to 103° F., and these attacks were always ushered in by a violent chill. The symptoms had been considered to be due to cancer of the liver or possibly abscess, and as the patient had already been more than two months in the hospital it had been pretty positively prognosticated that her span of life was rapidly drawing to its close. After having charge of the case for a week or more it struck me that the abdomen was very hard and doughy and that it could certainly not be amiss to give some purgative medicine. Accordingly she was ordered 'a pill of ext. belladonnæ gr. ½, ext. nucis vomicæ gr. ¼, ext. colocynth. comp. grs. ij, one to be taken three times a day. After taking this pill for eight days there was a note made that "she has been having from three to six stools daily and has passed a vast amount of very consistent old clay-colored feces." Inquiry into the history of this patient elicited the fact that for years she had been habitually constipated, that frequently she would have no movement of the bowels for a week at a time, and sometimes as much as three weeks had been allowed to pass without any. Gradually, under the treatment, the fever ceased, the attacks of chill followed by increase of fever did not recur, the jaundice disappeared, the liver grew smaller and the stools became of natural color, and at the end of three months the woman was discharged cured.

CASE VI.—Above five or six years ago I saw a woman of perhaps sixty years of age who had a small tumor which projected from beneath the arch of the ribs on the right side. After a careful consideration of the symptoms and physical signs, I concluded that it was an enlarged gall-bladder containing gall-stones. This patient had long been subject to attacks of jaundice which would be accompanied by pain in the region of the tumor. Before and dur-

ing each attack she was constipated, and she said she was always well so long as her bowels were freely opened, but that so soon as they began to be at all confined she feared and anticipated an attack of the pain and jaundice. I prescribed for her such a pill as has already been so often mentioned, and advised her never to allow herself to be constipated, but to take the pills sufficiently often to produce one movement of the bowels every day or at least every second day. Afterward she fell into the hands of another physician, who ascribed the tumor to some other cause and told her on no account ever to take any aperient medicine. This advice she followed, and not long afterward she had one of her attacks, of which she died. An autopsy showed an enlarged gall-bladder containing calculi.

CASE VII.—A woman of about sixty-five is affected almost exactly as was the one just described. She has a tumor projecting from beneath the arch of the ribs on the right side and for the past four years has been subject to attacks of jaundice with pain in the region of the tumor, and some disturbance of the stomach, manifesting itself by vomiting. During and before the attacks she is constipated. This patient has been advised that constipation is her worst enemy, and as she has learned to appreciate the fact herself, she never allows it to continue long. In the past two years her attacks have been very much less frequent and less severe than in the two previous years. The most careful search has failed ever to lead to the discovery of any gall-stones in her movements.

I know of two or three women all of them advanced in life, who for more than ten years past have seldom allowed a week to pass without taking a greater or less number of the previously mentioned pills and much more frequently they take one every night or second night. This particular combination does not seem to lose its effect after it has been taken for a long time, but, on the contrary, usually a less number of pills will suffice after the patient has used them for some time than was the case when the medicine was commenced.

There is one form of constipation which I never have been able to treat to my satisfaction, and it is that which is especially apt to occur during convalescence from typhoid fever, but sometimes also after attacks of other acute diseases. It is a very common occurrence in my experience after an attack of typhoid fever and when the temperature has fallen to subnormal, as always happens that where the bowels are moved, not having been so for four or five days, there is an attack of pain which is very severe, with utter inability on the part of the patient to rid himself of the fecal mass. This contingency, which arises in perhaps one-quarter of the total number of cases, cannot be explained upon the ground that the amount of fecal matter which descends from the colon is so much greater than the natural forces discharge on other occasions without difficulty or even pain. It seems as if the matter was of such a consistence, or descends in such a form, as to fill the rectum so completely that the unaided efforts of nature fail entirely for a long time to discharge it. Patients when such attack come upon them, are weakened by the disease from which they are just recovering and their nervous systems are so exhausted that they are ill able to contend with any further adversity; consequently, men who in health are strong and bold will lie in abject fright with the sweat rolling off them, and ready almost to cry with the pain and nameless state of helplessness in which they find themselves, because they feel the most urgent need to have the bowels opened and are utterly unable to accomplish it. The very attitude of people in this condition is characteristic and their efforts to relieve themselves most violent, until finally, paralyzed with pain and terror, they give up, and lie helpless and exhausted until something is done to relieve them. The position in bed assumed under these circumstances is one that, once seen and fully understood will never be forgotten: the patient usually lies somewhat turned upon one side so that the weight of the lower part of the body rests upon one buttock with the other raised from the bed, then



the shoulders are elevated and their weight supported upon the arm on the same side. No doubt, if a person was left in this condition, nature would in time, relieve the difficulty, but the remedy for the physician to make use of is a very simple one, and efficacious if properly applied; it is the injection of warm water. The physician should not content himself by simply giving directions to a nurse, but should himself superintend the administration of the injections for frequently several will have to be given before the desired effect is produced. The proper method to be pursued is to prepare a quart of warm water, and if the administrations of this does not give complete relief, in five minutes a second should be administered, and a third, and so on until relief is obtained. Sometimes as many as four or five will be required before this is accomplished.

To prevent the occurrence of this accident is a matter which has often engaged my thoughts, but as yet I have failed to get any light upon it. There are no symptoms that I have learned to distinguish to enable me to predict when the accident is likely to occur in either typhoid fever or others diseases, however, much I may have been on the lookout for it, and I am afraid to give aperient medicine in typhoid fever which would seem to be the only possible preventive, lest it should have an injurious effect upon the intestine, which presents the prime lesion of the disease.

The cases related have all been of exceeding interest to me and very instructive. They would seem to offer as much room for the exhibition of special skill in understanding and coping with new and unforeseen combinations of symptoms to be looked for, as there are in all the diseases we are ordinarily called upon to contend with; therefore the personal equation enters more largely into their successful management than usual, and a physician has rare opportunities to display his acumen as a diagnostician.

The lessons I have learned from them have been various, and I will endeavor

to describe them in detail for the benefit of those who may meet with parallel cases. The first case described shows how insidiously fecal accumulation may take place and how it may induce quite serious symptoms which have no very evident connection with their cause. The attacks of chill followed by fever and accompanied by nausea and vomiting continued for at least four or five years before their cause was even suspected, and light was obtained in a manner almost accidental, by the discovery that the rectum was full of sticky, clayey, fecal matter. It was difficult to believe there could be fecal accumulation in this case, for the history was clear that previous to most of the attacks there had been no apparent constipation, the bowels being moved every day, and before the discovery was finally made by the digital examination there had been diarrhœa. Some of these movements I myself saw, and they were large and loose. Nothing induced me finally to make the examination but a careful attention to the fretful description, given by the patient, of her own sensations and this opposition to the equally determined nurse that the complaints of irritating sensations and a feeling that the rectum was still full, were all nonsense. I have learned to think that as physicians we cannot too closely give heed to the descriptions by our patients of their own sensations, hearing patiently and without interruption all they may have to say that is at all pertinent to the subject, and then, of course depending equally entirely upon our own experience and knowledge to draw the proper inferences. I made my diagnosis then of fecal obstruction or accumulation in this case in despite of the fact that the patient had had her bowels opened every day for two months past; that for several days she had had diarrhœa, having several loose movements each day, and in despite of the fact that her nurse was convinced that the bowels had been too much and not too little opened, and I made it simply listening too little opened, and I made it simply by listening to, and giving due weight to, the complaining descriptions of the

patient of her sensations, and then insisting upon making a digital examination of the rectum.

Case II. teaches, from a slightly different point of view, the same lesson that is to be learned from the first, that the mere having the bowels opened by no means proves that there cannot be fecal accumulation, and that in sufficient amount to occasion grave disturbance of health. This woman, when recovering from an acute disease, was seized with constipation, and nausea, and vomiting. The constipation was apparently easily relieved by the use of as simple and mild a remedy as a seidlitz powder, for the administration of one always induced one or two watery passages, but still the other two symptoms persisted. It was only the discovery of the doughy induration along the line of the colon in an otherwise exceedingly flat abdomen that lead to the correct diagnosis, and this was fallen upon almost by accident, or perhaps instinct, in the course of a search for some explanation of the exceedingly puzzling and alarming condition. The cure was effected only after giving for a whole week the aperient pills, and I was able to persist so long, confidently predicting the result because my previous experience enabled me to be entirely satisfied in my own mind what the cause was, when once the idea had struck me.

The symptoms in Case III. resembled more nearly those present when there is a foreign body in the rectum than anything else, and the digital examination revealed that the pouch was empty except for the one small mass which was like a calculus, and which the patient's unaided efforts, injections, and pills entirely failed to remove.

The diagnosis was so obscure that it was only arrived at after between two and three weeks in Case IV., which was certainly one of surpassing interest. The symptoms so nearly resembled those presented in typhoid fever as to be very misleading, and it was only by a careful analysis of them that the correct conclusion was reached, that it was not a case of this disease, and after reaching this conclusion we were obliged to wait for

ten days before the true solution of the difficulty came to light. It is instructive and well worth remembering that obstruction of the sigmoid flexure alone, and this without doubt existed in this case, could cause so serious and complicated a train of symptoms. One of the most marked symptoms was the very decided tenderness upon pressure in the left iliac fossa over the region of the sigmoid flexure while there was none in the right. The diarrhoea, which was quite severe from the beginning, was induced by the doses of sulphur taken, and this, in fact, seemed to be the starting-point of this illness and was its direct exciting cause.

In Case V. the patient was thought to have cancer or abscess of the liver, but a suspicion of the true state of affairs was easily reached, for the abdomen had to a marked degree the peculiar doughy induration that is so characteristic to those who have learned to recognize it. To feel sure of the existence of fecal accumulation after once my suspicions were guided in the right direction was easy, and to prove this view correct, was equally so, for, after taking the purgative pills for eight days there was ocular demonstration of its existence. The knowledge, however, that this alone was the cause of all the very serious symptoms present, could only be reached by a process of exclusion and in the course of months, as the various disturbed organs and functions gradually returned to their natural condition when the irritating cause was removed, and the organic changes, one after another, disappeared with the relief of the fecal accumulation. It is a rare occurrence for fecal accumulation to continue until such dangerous conditions are induced as happened in this instance, and if relief had not been obtained when it was, or certainly a little later, the case must soon have had a fatal termination.

Cases VI. and VII. are interesting as showing how materially the comfort and well-being of persons suffering with gall-stones may be affected by the condition of the bowels. Careful attention to this matter seemed very necessary in both of them, and their comfort was de-



pendent upon them taking aperient medicine in such quantities as to produce regular movements of the bowels. It is likely that over-purgation in such cases would be as injurious as the contrary condition was proved to be.

The cases related, when considered collectively, teach many and valuable lessons. In the first place, they show the surpassing wisdom of the advice, which is commonly attributed to Bright, never to pronounce an opinion in a case of abdominal tumor without first having purged the patient, and they show further that the manner of the purging is more important than its mere performance. One or two doses of any of the ordinary purgative medicines cannot be depended upon to accomplish the purpose, the doses must be small and frequently repeated, and the course must be persisted in for some time. The pills of belladonna, nux vomica, and compound extract of colocynth are in, my experience, unfailing, if their use is continued long enough. Large, single doses of medicine may produce watery movements as under ordinary circumstances, but they seem to fail entirely to dislodge the offending fecal matter which must lie in the sacculi and at the sides of the large intestine, as it is so often seen at post-mortem examinations. The large doses seem to throw the intestine into a short-lived spasm of violent activity, the result of which is the secretion of a large amount of watery matter which comes away leaving the condition of affairs almost totally unchanged. The medicine must be given in such small and slowly acting doses as to give time for the peristaltic movement of the whole intestine to be increased, and the result will be certain. The amount of fecal matter that can accumulate in the intestine without serious disturbance of health so long as a central channel is open is amazing, but a time must come when a sufficient quantity of this will move from its resting places in the sacculi and at the sides of the canal to cause a more or less complete block of the whole calibre of the bowel, and then nature can never rest until the way is

clear again. If by some means, either by the unaided efforts of nature, or with the help of a purge, the channel is not soon opened, nausea and vomiting are inevitable. For the production of these two latter symptoms the block must be complete, and the truth of this statement is evidenced by what occurred in the first five cases narrated. In Cases I. and II. the block was complete, and there were nausea and vomiting. In Case IV. the block was probably very nearly absolute, for nothing passed but thin watery passages, and in that case there was nausea, but no vomiting. In Cases III. and V. there was every reason to believe that at no time was the obstruction complete, and in neither of these cases was there marked nausea or vomiting. It is strange that all these patients should have been women, and for this no adequate explanation is at hand which satisfies my mind, for I consider the old explanation that women are careless about having their bowels moved a very poor and insufficient one. The two combinations of medicine which have been recommended in pill form proved efficacious in every case except the third, and in that instance it subsequently appeared that the mass to be passed was too large for the anal orifice, which was contracted and the muscle hypertrophied as a consequence of long-standing sphincterismus. So far as diagnosis is concerned, it is difficult to discuss, for the solution in each case differed so materially from that in every other one that no rules can be laid down. The physician must depend largely upon his individual acuteness in diagnosis, not allowing himself to be led astray either by a distinct history that in the past weeks or months his patient has had the bowels moved sufficiently often, or by the fact that single doses of purgative medicine produce watery movements of the bowels in about the usual way. The diagnosis must be made from a careful inquiry into the history, which will often show tendencies that may lead to the correct solution, and this must be followed by an equally careful physical exploration of the abdomen, and if there is the

slightest reason to suspect any intestinal difficulty, digital examination of the rectum.

#### DISCUSSION.

*Dr. J. M. DaCosta* said: A point of particular interest is the occurrence of fever in these cases. I saw the fourth case with *Dr. Meigs*, and the fact that it simulated typhoid fever so closely is a matter of interest. I have seen a similar case in which there were almost identical symptoms, with an almost identical termination. We see from this case and the others referred to, that constipation may cause fever which is continued and may present the symptoms of a low type.

There is another point connected with the occurrence of constipation in fever to which *Dr. Meigs*, did not have occasion to allude; that is to say, sometimes after low fevers in which the state of constipation to which *Dr. Meigs* has called attention, occurs, relapse of the fever will be developed by the constipation. We grope around in darkness wondering what may be the cause, thinking that it is a true typhoid fever relapse, when by giving small doses of oil or of laxatives, both the fever will disappear and the bowels be freely moved. I have seen this state of things keep up for five or six days; and I think that a good many cases of relapse in typhoid fever have their origin in the very condition to which *Dr. Meigs* has alluded and to which I now call the attention of the College.

I will go further, I have reason to think that in some of these cases there may be well-developed typhoid fever symptoms with rash, due to constipation, which will disappear when the bowels are moved. I have seen the same after remittent fever. It seems to me that the occurrence of constipation after fever, typhoid or malarial, may lead to the redevelopment of the febrile state, which may be considered a relapse, when in reality it is only the same kind of irritation of the bowels which in Case IV., of *Dr. Meigs*, produced a fever of low type, when there was not the slightest reason for suspecting typhoid fever.

*Dr. James H. Hutchinson*: Case IV. was probably not a case of simple constipation, but one of enteritis associated with the constipation. The enteritis was probably the cause of the fever and not the constipation. In regard to constipation causing relapse in typhoid fever, I think that it is well-known that the cases in which constipation has occurred, are more apt to have relapse. I have not myself seen a great deal of constipation follow typhoid fever. At present I cannot recall a case of relapse in which it could be attributed to constipation.

#### OVARIOTOMY, WITH THE HISTORY OF A CASE.\*

BY ROBERT T. WILSON, M. D.,

Gynæcologist to the Union Protestant Infirmary;  
Assistant Surgeon to the Hospital for the Women  
of Maryland.

[Multilocular Ovarian Cyst; removed by incision through the linea alba, of three inches; pedicle ligated with silk, returned to the abdominal cavity; drainage; recovery.]

The patient, whose history forms the subject of this report, is the mother of three children, two girls and a boy, the youngest child a girl, being now two years old. She has been married eleven years, and is the second wife of her husband. She has just reached her thirty-fifth birthday. At the age of thirteen she first menstruated, and it has always appeared every four weeks ever since, except when she became pregnant. When her last child was born she did not suffer with labor pains, like she had with the other children, this time her feelings were severe cramps in the lower part of the abdomen; and no pains in the back. She was only two hours in labor, it being also the easiest of any, considering it upon the whole. While she carried this child she always had a soreness in the left groin. Bowels were moved every day without medicine. After the labor, the abdomen did not go down as it

\*Admission Thesis to the Baltimore Academy of Medicine. Read June 1, 1886.



did after the birth of the other children; so that she could not tell me when the abdominal enlargement began. In July, 1884, she had feelings as if her womb had fallen out of place, so she consulted a physician near her home; he placed a cup-shaped pessary in the vagina, telling her it would keep her womb up. In November, 1885, she consulted my father, Dr. H. P. C. Wilson, and upon making a digital examination, he found that she had a retroverted uterus, and that the cup pessary was buried in the vaginal tissue, and had made a sulcus, deep enough around the cervix uteri, to bury the finger in it. On removal of the pessary there was profuse hæmorrhage from the sulcus; the effect of the pessary had been to raise the cervix high, and throw the fundus uteri more firmly back into the hollow of the sacrum, where it was firmly fixed in surrounding lymph. Upon further examination he diagnosed cystic tumor of the left ovary. She remained awhile for reparation of the damages done by the pessary; then returned to her home to pass her menstrual period, which was approaching. She returned to the city, December 12th, and entered the Union Protestant Infirmary, under my care. She then told me, in addition to the above history, that she did not suffer with her last menstrual period, or with it prior to that period. Upon examination per vaginam I found the uterus retroverted and kept down by adhesions. Upon palpation and percussion I diagnosed a multilocular ovarian cyst of the left ovary. The patient being prepared, on the 15th of the same month I operated, the Anæsthetist being Nathan R. Gorter, M. D. An incision of two inches through the linea albæ was made; as soon as the peritoneum was cut through and abdominal cavity reached, out poured a great quantity of serous fluid, blood being mixed with it. The tumor was found to be strongly attached to the abdominal walls, to the left of the incision. The incision was enlarged and the adhesions broken up. Sir Spencer Wells' trocar was plunged into the tumor, and at once was discharged fluid of a chocolate color. A second

cyst, upon being tapped, discharged a clear viscid fluid. The hand was now introduced into the tumor and several smaller cysts broken up; grumous fluid containing flocculent lymph now flowed from the tumor. Upon the tumor collapsing the omentum was seen to be closely adherent in several places to the superior-posterior part of the tumor. Some difficulty was experienced in separating these adhesions, which, on being done, bled, but were immediately clamped and tied with Chinese silk. The intestines were also adherent to the posterior part of the tumor; with care they were peeled from the tumor. The tumor was now raised out of the abdomen. The pedicle was found to be one inch and three quarters in width and of medium length. I now transfixed it with my temporary clamp, tied it with a double ligature of Chinese twist silk, cut it off and returned into the abdomen. After the peritoneal cavity had been carefully sponged, it was found that some oozing of serum mixed with blood continued. As ligatures had been left upon the omentum, and this oozing continued in the cavity, it was deemed advisable to provide for drainage, so I inserted a soft rubber drainage tube with holes cut into it by myself, where I thought they were needed, the tube reaching down into Douglas' cul de sac, and out through the lower angle of the incision. The abdominal wound was closed with seven silver wire sutures, and dressed antiseptically. Time of operation forty-five minutes. The patient was now placed in bed, with warm applications to her feet. During the operation her body was kept warm with hot bottles and blankets. She reacted very well. At 9 o'clock, P. M., I examined the dressing, and fully 3ii of bloody serum had been discharged, and it was still running from the tube. I withdrew from the tube, with a hard rubber syringe, having a long nozzle, the fluid, and washed out the cavity with boiled water blood heat, made further antiseptic with carbolic acid (1-40); fresh dressings applied. She passed her urine without any trouble into the bed pan. On the morning of the second day the

dressings were removed, and fully 3i of bloody serum had run out and the tube was only partly filled; the cavity was treated in same manner as the night before; wound looked well. General condition of the patient good. Night of the second day dressing removed, about 3i fluid discharged, tube being half-full; same management continued. Morning of the third day, dressings removed, very slight discharge had occurred since last night; same treatment observed. Night of third day, discharge stopped, tube removed. Wound looked well; dressed it antiseptically. General state of patient good. Morning of fourth day, wound looked well, no discharge from it, dressed it as usual. She so continued and made an uninterrupted recovery.

The greatest point of interest in this case, was the drainage tube. From the amount of bloody oozing from the points, where the tumor was attached, which even the most thorough sponging and afterwards touching with liq. ferri. sub. sulph. did not stop, and judging from cases I have seen in my father's and my own hands which also recovered, I am confident that this patient's life was saved by the drainage tube.

Before taking my seat, I desire to show a photograph which I made myself, which shows the appearance of the abdomen prior to operating.

### Society Reports.

#### THE BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD MAY 18, 1886.

##### IRIDINIZED PLATINA NEEDLES.

*Dr. J. J. Chisolm* exhibited a series of needles of various sizes, the invention of Dr. Genese, of this city, a description of which is here given in a note for the inventor.

They are made with platinized gold head, hardened under hydraulic pressure. This needle can be made as dense as steel, but will be found to work better, if the temper is below

spring steel. It will pass through tough tissue easily and cannot be broken, while the advantage of bending, if required, may be found of great service in some cases. This needle will pass through cartilage or dense cicatricial tissue. If iridium is added in the construction of this needle, it will be so hard that steel can be cut with it. This needle can be made of any shape or size and it is indestructible under the pressure of the forceps or the action of acids. The eye of a needle is the part hardest to clean; this needle can be cleaned with nitric acid, thus making it a somewhat antiseptic needle.

*Dr. S. C. Chew* reported an interesting case of

##### OPIUM POISONING.

He was called in consultation to see the patient, a lady who had been suffering from a severe attack of erythema nodosum, for the relief of which she had been getting a quarter of a grain of sulphate of morphia each night for four nights. On the fourth night she became comatose, a weak irregular pulse set in and a Cheyne-Stokes respiration appeared. The weak irregular pulse the Doctor considered as contra-indicating poisoning by opium. She was at the time supposed to be beyond relief. Hypodermic injections of brandy and tr. of belladonna were, however, ordered but gave no relief. At about 5 o'clock on the morning following she was apparently past all aid, but as a last resort the attending physician gave her a hypodermic injection of tr. of belladonna alone of about twenty-five minims. To his surprise she began to rally and by 9 o'clock of the same morning she was out of danger.

##### MORPHIA TAKEN FOR QUININE—MERCURIAL INUNCTIONS FOR LICE.

*Dr. F. T. Miles* related a case of a man who was poisoned by taking morphia for quinine, and when seen was apparently so near dead that therapeutic aid was considered useless. The patient recovered without any treatment whatever. The doctor has never seen a



patient die during the Cheyne-Stokes respiration.

Dr. Miles referred to a case of a young man supposed to be syphilitic who had become paralyzed. The man was completely paralyzed, there was dribbling of urine, bed sores and semi-unconsciousness. He was in a most disgusting condition, being filthy and in the hairy portions of his body infested with lice. Mercury was ordered internally for the syphilis and mercurial inunctions for the lice. The man made a rapid and complete recovery which the doctor attributes to the rapidity with which his system was brought under the influence of the mercury, not so rapidly when given by the mouth as when rubbed into the surface—the object thus obtained was not intentional, as the inunctions were ordered as stated for the lice, but the result certainly suggests a valuable means of getting the rapid action of mercury.

*Dr. J. J. Chisolm* related a case of

OTORRHOEA

that he had been called in consultation to see. The patient was in a very precarious condition. He was in a semi-comatose condition and was at times unconscious. The mastoid region was painful but not swollen. Pus oozed from the ear. There was aphasia but no paralysis. He decided to open the mastoid cells but upon a second consideration, as the patient was apparently moribund, concluded to try the effects of a large blister to the nape of the neck extending well down over the shoulders. The effect was pronounced; recovery was complete and the patient is now in good health.

STATED MEETING HELD JUNE 1, 1886.

The executive committee reported favorably upon the thesis presented for admission by Dr. Robert T. Wilson and he was accordingly elected to membership of the Society. Under the heading of "relation of cases,"

A SINGULAR COINCIDENCE IN THE HISTORY OF CANCER.

*Dr. J. J. Chisolm* related a singular coincidence that recently came under his observation. It was a case in which he was called upon to amputate a cancerous external ear from an old man æt. 80. The coincidence rests in the fact that this man had had two wives both of whom had had cancer, and both of whom had died as a result of the operation. Dr. Chisolm's patient, however, is still living.

ENUCLEATION OF THE EYE-BALL IN AN INFANT.

*Dr. J. J. Chisolm* related the history of a patient two months of age upon whom he had done the operation of enucleation of the eye ball for intra-ocular trouble. The patient recovered. This is the youngest subject upon whom he has ever performed this operation.

*Dr. J. Edwin Michael*, in answer to a question by Dr. Miles, said that it had been his experience that young children stand the strain of operations to which they are sometimes subjected remarkably well.

*Dr. G. Lane Taneyhill* two years ago amputated a terribly crushed leg from a boy 2 years old. The patient suffered only a moderate degree of shock from which he recovered entirely. The boy is now in excellent health.

DEFICIENCY IN BOTH LOWER EYELIDS.

*Dr. J. J. Chisolm* spoke of a case of deficiency of both lower eye lids, the result of cicatricial contraction from two scars on either side of the nose. The scars were the result of operation for the closure of a very high degree of double-hare lip. The fissures extended almost to the inner canthus of each eye, and back through the bony portions of the face, there being an absence of the inter-maxillary bones.

RESTORATION OF SIGHT BY A FALL.

*Dr. G. Lane Taneyhill* had recently

a patient, a lady æt. 65 years, who had fallen down stairs striking upon the right supra-orbital ridge, causing laceration, ecchymosis and a considerable degree of hæmorrhage. The patient claims to have been born absolutely blind in her right eye. One week after the accident, while the doctor was dressing the wound she suddenly exclaimed that she could see. Upon examination he found that there was perception of light and that when held in certain positions she could count fingers. There is apparently no lense present but there is a calcareous condition of the capsule with a superior synechia. He thinks the explanation for the sudden transition, is that in the fall there was a displacement of some of the opaque media, thus making an opening for the passage of light.

*Dr. J. J. Chisolm*, notwithstanding the evidence of the woman's absolute blindness, don't think she was ever without appreciation of light. Absolute blindness means atrophy of the optic nerve, and he is acquainted with no means by which an atrophy of the optic nerve of sixty-five years standing could be restored to a functioning condition. He thinks her so-called blindness only a matter of contrast.

#### DAINGER OF ATROPHIA IN PLUS TENSION.

*Dr. Herbert Harlan* made some remarks in which he wished to call attention to the danger of instilling atropia into an eye with plus tension. He said he recently had a case of choroidal atrophy that gave nothing to suggest a plus tension, nor any glaucomatous formation. Wishing to demonstrate the atrophy more clearly to his class he dilated the pupil with a few drops of atropine solution. On the following morning the fundus and transparent media were opaque and cloudy and the eye was very painful. An iridectomy resulted in complete relief. But the case has impressed itself upon his mind, and forms the substance of these remarks in which he wishes to caution others against the use of atropine until the tension of the eye has been carefully tested and glaucomatous trouble is absolutely excluded

*Dr. J. J. Chisolm* said it was not uncommon for acute glaucoma to be set up by the careless and injudicious use of atropia.

*Dr. Robert T. Wilson* then read his admission thesis upon

#### OVARIOTOMY WITH THE HISTORY OF A CASE.\*

##### DISCUSSION.

*Dr. B. B. Browne* said that in his practice he had substituted irrigating the abdominal cavity with warm water eabolized, for sponging, as it subjects the abdominal viscera to less violence. His results have been very favorable.

*Dr. J. J. Chisolm* then read a very interesting paper upon

#### A COMPLETE REVOLUTION IN THE AFTER TREATMENT OF CATARACT OPERATIONS.

The method had been suggested to him by *Dr. Michel*, of St. Louis, whom he had seen at the last meeting of the American Medical Association. It was brought before the Section on Ophthalmology, but did not meet with their approval.

*Dr. Chisolm*, however, decided to make a trial of the plan suggested and his results have been so favorable that he has now discarded entirely the old method of bandaging and incarceration of the patient in a dark room, for the new method of simply closing the eye in its natural position and retaining it so by a bit of light adhesive plaster, and allowing the patient the liberty of lighted rooms.

The advantages claimed are first, that a more uniform pressure can be obtained through the natural muscularity of the lids than by any artificial padding that might be employed; and second, that patients who have not been shut out from the light are less sensitive to its action when the eye is sufficiently healed to permit of its exposure, than those who have been retained in darkened rooms.

Moreover it admits of a means of entertainment for the patient for they can

\*See page 141.



then have their friends read to them, a privilege denied patients treated under the old plan.

The new method recommends itself especially because it possesses in a most limited degree any procedure that alters to a great extent the normal relations of the patient. The method in detail is simply this, after the removal of a cataract or the performance of an iridectomy, the eyes, if a cataract, the eye if an iridectomy, is closed in its normal position and a bit of isinglass plaster about two and a half inches long by one inch wide is then rendered flaccid by immersion in some germicide fluid and is neatly applied to the surface of the closed lids. When dried this forms a close firm band. The patient is then allowed the full liberty of his room and in every case thus far operated upon the results have been uniformly good.

The Doctor has treated eighteen cases, (fourteen cataracts and four iridectomies) in this way and many of them go out from the hospital into direct daylight without even as much as smoked glasses to protect them, and they complain of no photobia nor lachrymation. On the sixth day, when the plaster is removed the eye stands the light better than it did on the tenth day under the old method. The length of time required for complete healing of the eye operated upon is on an average about two weeks, but the most of the eighteen cases could have left the hospital on the tenth day.

Under the head of miscellaneous business, this being the last meeting of the present session, the following officers were elected for the ensuing year: President, Dr. P. C. Williams; vice-president, Dr. Alan P. Smith; treasurer, Dr. G. Lane Taneyhill; secretary Dr. C. C. Bombaugh; executive committee, Dr. J. J. Chisolm, Dr. J. Edwin Michael, and Dr. A. B. Arnold.

The Society then adjourned to meet the first Tuesday evening in October next.

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At a meeting of the American Surgical Association held in Washington on April 30th, 1886, Sir William Mac Cormac was elected an Honorary Fellow of the Society.

THE RADICAL CURE OF VARICOCELE.—To the large number of operations which have been devised for the cure of varicocele yet another has been added by M. Richet, of the Hôtel Dieu. It is described in the *Revue de Chirurgie* for April by Mr. Picqué, who is disposed to laud it. The vas deferens is first separated from the bundle of veins to be obliterated and held out of the way by a thread of copper wire passed through the scrotum in an armed needle. The veins and the fold of the scrotum over them are then grasped by the blades of forceps heated to a red heat, such as M. Richet uses for the destruction of hæmorrhoids. A wound of some size is left, and cicatrization is obtained in about three weeks. M. Picqué argues that excision of the veins is the best of all the many operations for varicocele, but that it should only be undertaken by those who are quite familiar with the aseptic treatment of wounds. In cases where the surgeon is not confident of his ability to keep the wound aseptic he recommends Richet's operation. We cannot join in such advice. Richet's operation appears, from the description given of it, to be a very rude method of obtaining a result more easily, more quickly, and better obtained by other means.—*Lancet*, May 8, 1886.

CATARRHAL HEADACHE.—Iodide of potassium is said to quickly relieve the dull headache so often accompanying an ordinary cold in the head. Two grains may be dissolved in a glassful of water, which is to be taken in little sips during half an hour. Dr. Davis recommends this simple remedy, and says he has hardly ever known it to fail.—*Med. Record*.

METHYL IODIDE IN GYNÆCOLOGY.—Dr. Robert Kirk (*Lancet*, Oct. 24, 1885) recommends this preparation instead of Churchill's tincture for application to the cervix uteri and the vaginal vault. It is said to have an anæsthetic as well as a resolvent action. After an application has been made to a sensitive endometrium, a sound may be passed without pain.—*New York Medical Journal*.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, JUNE 19, 1886.

**Editorial.**

THE THOMAS WILSON SANITARIUM AND ITS HUMANE WORK.—As the summer season approaches the diseases peculiar to infantile life occupy an important place in the minds of the majority of medical practitioners, and especially among those who work in the densely populated sections of all large cities. Any agencies or influences which may improve the conditions which surround the infant population are at this time entitled to special consideration. Those physicians who work among the infantile diseases peculiar to the summer months are prompt to recognize the great value of hygienic influences over drugs in the treatment of these affections, and attest this fact by sending their little patients to localities more favorable in their hygienic surroundings than are to be found in the close and sultry houses of our cities.

The annual exodus of mothers and children to rural districts at this time of the year is a most fortunate circumstance in diminishing infantile mortality, and it is a matter of serious regret that this privilege cannot be enjoyed by a larger number of mothers and children. Whilst many of the largest cities of this country provide, in a measure, for their infant population by supplying free excursions by rail and water, free medical attention, and free milk and ice, we are most fortunate in having in our own city an Institution which does more than this

in offering a summer resort to destitute mothers and infants where every care is given to the prevention and cure of infantile diseases prevailing during the summer months. The Thomas Wilson Sanitarium is an Institution founded upon noble sympathies and practical benevolence. It extends a strong arm of help to our suffering poor by taking under its protection those least able to help themselves. Though only having an existence of some three years, this charity has done an excellent work in this community, and has practically demonstrated the good results which can be made to flow from wealth properly bestowed and wisely administered.

To the Trustees of this Institution great praise is due for the prompt and practical manner in which they have inaugurated this work, as also for the solid foundation they have laid for the future development of its benevolent features.

The Sanitarium has been located twelve miles from the city, on the Western Maryland Railroad, in a valley of healthful surroundings and picturesque beauty. The grounds and buildings are amply suitable for the practical administration of the work undertaken, and the various details for reaching those in need of the charity, and for providing for their benefit, have been worked out with great system and painstaking effort. Over 8,000 mothers and infants were provided for during the past summer. The Trustees fully expect that the number cared for the present summer will reach 10,000. Out of this number of individuals it would be difficult to estimate the annual gain in life, health and comfort. In the successful conduct of this benevolent work the Trustees of this Sanitarium appeal to the aid and coöperation of the medical profession of our city. The profession is urged to send to the Institution such cases as need its benefits, and in doing this no personal sacrifice of time or service is demanded. The Sanitarium takes up a work the profession cannot discharge and thereby directly aids each and every physician in the treatment of such cases as most need hygienic assistance. In order to fully set be-



fore the profession of our city the practical details of this charity, the Trustees courteously invited the profession to visit the Sanitarium on the 11th inst. This invitation was responded to by some 200 physicians on the day named. In appropriate addresses made by His Honor, Mayor Hodges, by Mr. Francis T. King, the President of the Board of Trustees, and by Drs. Richard Gundry, P. C. Williams and James Carey Thomas the objects and plans of the Institution were fully explained and set forth to the intelligent audience of medical men assembled. The wisdom of the Trustees was well shown in this act of courtesy to the practitioners of our city, and we predict a cordial response upon their part to the appeals of the Institution.

There is one side to the work of the Sanitarium which commends itself to the medical profession at large. We refer to the ample provision which has been made by the Trustees for the practical and scientific study of infantile diseases, which is conducted by the medical staff of the Institution under the direction of Dr. W. D. Booker, of this city. This medical work is going on under most favorable auspices, and such observations as are made in hygiene and diet, and in pathology and treatment are carefully recorded for subsequent criticism and ultimate publication. Dr. Booker has devoted much labor to the study of bacteriology in connection with the stools and dejecta of the various diseases of the alimentary canal to which infants are subject, and his observations and conclusions will ultimately be given to the profession. It is believed that the facts now accumulating in his possession will ultimately prove exceedingly interesting and valuable.

We cannot close these remarks without congratulating the medical profession of our own city, and country at large, on the fact that we have in Baltimore such Institutions for the promotion of learning, scientific culture and benevolence as the Johns Hopkins University and Hospital, and The Thomas Wilson Sanitarium. These, with the other Institutions of benevolence at work in our midst, are dispersing large sums

of money each year in the cause of human suffering, the principal of which has been estimated at the enormous figure of fourteen millions of dollars. With a population of four hundred thousand people can any of our sister cities show a larger contribution to education and charity? We think not.

PASTEUR AND HIS EXPERIMENTS CONCERNING HYDROPHOBIA. — For some months past the scientific world has been captivated by the various announcements made from the Pasteur Institute concerning the work of the distinguished savant who claims to have discovered a specific virus for the prevention of hydrophobia. From all parts of the world persons supposed to have been bitten by rabid animals have flocked to the École Normale, in Paris, and have submitted to M. Pasteur's inoculation experiments. The interest created in these inoculation experiments and the panic excited in the minds of those who have believed themselves victims of rabid animals is something unprecedented. A veritable craze upon the subject is the mildest way of expressing the rush made to Pasteur for protection. In the latest communication made by Pasteur to the Academy of Medicine, he stated that he had treated the enormous number of 950 cases between July 7, 1885, and April 12, 1886, all of which cases claimed to have been bitten by rabid animals (wolves and dogs), and were therefore suitable subjects for his experiments. Among this number of cases—including the little girl brought to him thirty-six days after being bitten—eight deaths have occurred, six of which were in cases bitten by wolves, and the last victim, a Roumanian, who had been bitten by a mad dog on May 11th, was put under treatment fourteen days later, and died on June 7th. Throughout all of his experiments Pasteur has been very confident of his ultimate success, and latterly has had the courage to assert that "the prophylaxis of hydrophobia is established."

Whilst having the highest admiration for the earnestness, honesty and skill of the distinguished experimenter, we are

wholly unable to admit the correctness of this proposition, and are far from believing that he has established his theory of prophylaxis upon ground that will stand the test of time. That Pasteur is sincere in his faith we doubt not; but the evidence thus far presented is not sufficient to establish the truth of his conclusions to any honest scientific mind. Whether the investigations now being pursued will lead up to the full confirmation of his theories is a matter of purest speculation. We see no reason to doubt the carefulness and system with which his experiments are conducted, but it does seem to us that his theory is founded upon unsound reasoning, and will therefore, sooner or later, fall into discredit. The way in which Pasteur attempts to account for the death of the cases bitten by wolves is a mere begging of the question, and offers no more satisfactory explanation than the mere assumption that the bite of the rabid wolf is more dangerous than the bite of the rabid dog, a fact which has not been proved by Pasteur or any one else. The recent death of the Roumanian patient is a much harder nut for Pasteur to crack, for all the facts previously claimed have been controverted by this case. Thus, for example, this man was bitten by a rabid dog, treatment was promptly instituted and conducted for eleven days, and yet death occurred within less than thirty days after the rabid bite was inflicted. The most singular fact in connection with Pasteur's claim is the assertion that of the 950 cases treated by him all were bitten by rabid animals and all now enjoy the benefit of his prophylactic inoculations. What makes this statement more striking is the fact that until Pasteur announced his views, about one year ago, hydrophobia was an extremely rare affection, and was so infrequently observed among human beings that the annual deaths from this cause were scarcely worth naming. How very suddenly it has leaped into prominence as one of the great scourges of the human race the results of the past few months offer abundant proof. It would be impossible, we think, for Pasteur to prove that even 25 per cent.

of the cases presented to him for inoculation were in the slightest danger of hydrophobia prior to his treatment, and hence we cannot but resist the conclusion that he has inoculated many cases which stood in no need of his experiments. Upon what ground he can now claim protection for these patients through his methods of inoculation we are unable to see. To claim protection for a condition which does not actually, and probably never would have existed, is simply an assumption, not a proof of his theory. Whilst we have no desire to disparage the meritorious work of this great savant, we must judge his work in a calm light and withhold our acceptance of his facts until better proof has been presented than has at present been offered. In the light of his present results we do believe a prophylaxis for hydrophobia has been discovered, unless it be in an extremely modified form.

### Miscellany.

#### SUDDEN DEATH IN PREGNANCY, PARTURITION, AND THE PUERPERAL STATE.—

In a paper read before the Harveian Society, May 6th, (*Lancet*, May 27th, 1886) Dr. M. Handfield Jones briefly traced the history of the evidence on which hypertrophy of the left ventricle in pregnancy rests, and raised the question whether this hypertrophy was ever wanting, and if so, what were the results. Cases were detailed in which clinical investigation showed apparently absence of all hypertrophy, and in such patients signs of cardiac failure and insufficiency were observable; the possibility of repeated miscarriage being also referred to this cause was shortly touched upon. Attention was drawn to the close tie existing between the heart and the uterus, and the extreme probability that the return of the heart to its normal size after delivery was, as in the case of the womb, due to a gradual process of fatty metamorphosis. While under healthy conditions this process was devoid of danger, arguments were adduced to show that in some patients this process of fatty change might overstep the normal boundary, and by weak-



ing the cardiac muscle leave the heart liable to be overwhelmed by secondary conditions insufficient in themselves to bring about a fatal issue. Cases were read in support of this view. In conclusion, some of the cases quoted in the literature of sudden death in and after pregnancy were brought forward, and the explanation given of death in the various cases criticised, with the purpose of showing that in most of these the fatal result could be more scientifically accounted for under the view already enunciated than by referring them to such obscure conditions as idiopathic asphyxia, &c. Dr. John Phillips mentioned a case in which albuminuria and oedema had been present, but no hypertrophy of heart or evidence of actual renal inflammation. Premature labor had therefore not been induced. Was it always advisable to induce it where there was reason to suspect fatty degeneration during the later months of pregnancy? Dr. Champney's thought that the changes in the vascular conditions before and after pregnancy were not fully understood. Cases of true cardiac insufficiency from rheumatism were often unsuspected until pregnancy occurred. In 75 per cent. of the cases recorded by Dr. Angel Money there were murmurs of some kind, but mostly transient. Fainting and sudden death were liable to occur even without hæmorrhage, and for this reason especial care was necessary for many hours after delivery when there had been much loss of blood. Mr. George Eastes referred to clotting of blood in the pelvic veins and pulmonary embolism, and to ruptured uterus and post-partum syncope, as other causes of sudden death. Dr. Morton believed that the alteration in the character of the blood had much to do with the formation of the clots referred to by Mr. Eastes. Dr. M. Handfield Jones, in reply, advocated induction of premature labor in the cases referred to by Dr. Phillips. He was not aware of the average duration of the physiological hypertrophy after delivery.

SYNCOPE IN ADOLESCENTS.—Dr. Clement Dukes, of Rugby, Physician to

Rugby School, writes to the *Lancet* (May 8, 1886): "Can you afford me a little space to call attention to a clinical fact of some moment, which is not sufficiently known, or, if known, not sufficiently acted upon in the interests of science and for the welfare of our patients.

An adolescent was sent to me with the statement that he had nearly fainted on three different days, but he did not become insensible. He came with the request that I would ascertain the cause of his faintness. Cases of the kind have happened to me under similar circumstances so many times, and their relief at first has been so unsatisfactory and difficult, that my experience may be of value to others, for I have established a fact. I have already incidentally referred to this fact in a former communication, but not so clearly or with such certainty as I wish to do now.

When such cases come under my investigation, I immediately and invariably examine the urine, instead of the heart, and generally find it loaded with albumen. It is therefore highly important that the urine should be examined and the kidneys treated by nitro-glycerine, rather than the heart auscultated and tonics prescribed, 'because of the patient's extreme debility and feeble action of his heart, &c.,' as is usually the case. I have sometimes found, on examination of the heart and pulse, that, besides the marked albuminuria, there exists a heaving heart and somewhat rigid arteries—conditions incidental, I believe, in adolescents, more to the 'age of puberty' than the state of the kidneys. But often, as in a case at present under my care, the heart is really feeble and the pulse totally devoid of the signs of a kidney pulse; and had it not now been my invariable rule to examine the urine in preference to the heart, I should doubtless have prescribed a tonic regimen, to the detriment of my patient. The treatment for the two conditions is so opposite that I do not hesitate thus to call special attention to it: a feeble heart and pulse being relieved by tonics, good food, and stimulants; while congested kidneys are alone cured by a hot bath,

nitro-glycerine, an aperient, and milk only as a diet. With such treatment this syncope of adolescents is usually cured in a few hours, and with daily prudence for some time there will be no return of syncope or albumen, and the patient will express himself as vigorous again."

#### THE USE OF MALT LIQUORS IN FUNCTIONAL DISTURBANCES OF THE HEART.—

Dr. Charlton R. Gulick sends to the *N. Y. Med. Journ.*, an account of the case of a man who, after an attack of measles, had acute lobar pneumonia, for which he was not treated. This in turn was followed by severe bronchitis, and Dr. Gulick was called in. The patient did well under treatment; little if any pleuritic thickening was left, and no organic disease of the heart was to be discovered, but he began to suffer with palpitation of great severity and persistency, which proved very refractory to treatment. Electricity was first used, then quinine, and then digitalis. The use of the drugs was pushed to the fullest extent, and finally Duquesnel's digitalin was used hypodermically, but this proved exceedingly objectionable to the patient, and lager beer was ordered. Within seventy-two hours marked improvement was observed. At first the improvement was imputed to the use of the drugs, but the question was tested by withholding the beer and continuing the use of the medicines. Within three days the palpitation returned in all its original severity, but was again removed, never to return, by suspending all medication except the use of the beer. There was gastric disorder in the case. Dr. Gulick commends the use of lager beer in rebellious cases of functional derangement of the heart.

THE ASSOCIATION OF AMERICAN PHYSICIANS.—The first annual meeting was held in Washington on Thursday and Friday, the 17th and 18th inst. The programme announce the following papers: An Address by the President, Dr. Francis Delafield, of New York; "Knee-jerk and Muscle-jerk in Disease" by Dr. S. Weir Mitchell, of Philadelphia, in conjunction with Dr. Morris J. Lewis; "Typhoid Fever," by Dr. F.

Peyre Porcher, of Charleston; "Spasm of the Larynx in Rickets," by Dr. J. T. Whittaker, of Cincinnati; a discussion of the question "Does the Present State of Knowledge justify a Clinical and Pathological Correlation of Rheumatism, Gout, Diabetes, and Chronic Bright's Disease?" (referee, Dr. James Tyson, of Philadelphia; co-referee, Dr. W. H. Draper, of New York); "Notes on some Cases of Diaphragmatic Pleurisy," by Dr. E. T. Bruen, of Philadelphia; "Certain Elements found in the Blood of Malarial Fever," by Dr. W. T. Councilman, of Baltimore; "Certain Clinical Facts connected with Tabes Dorsalis," by Dr. H. N. Lyman, of Chicago; "Diseases of the Appendix Cæci," by Dr. Reginald H. Fitz, of Boston; "Perimetritic Inflammation," by Dr. W. M. Polk, of New York; "An Experimental Study of Glomerulonephritis," by Dr. W. H. Welch, of Baltimore; and "Bicuspid Condition of the Semilunar Valves," by Dr. Wm. Osler, of Philadelphia.

THE FECUNDITY OF MICROÖRGANISMS has been so often demonstrated in explanation of the suddenness of appearance of them in multitudes, and of the virulence of infectious disease, as to require mention here only for the purpose of checking the riots of the imagination. It is known that a particle from a milz-brand bacillus, so small as to be invisible under an ordinary lens, introduced beneath the skin of a guinea-pig, multiplies sufficiently to kill the animal in forty-eight hours, and a drop of the blood of the animal thus affected, properly inoculated, destroys the largest ox in a few days. It is useless to dwell upon this point of propagation. It was the recognition of it that compelled the return to the germ theory of infectious disease when it seemed to have been routed even with contumely. No purely chemical substance possesses this property. The power of reproduction or self-multiplication is limited to living things. Chemical substances admit of great subdivision, as best exemplified, perhaps, in the dissemination of odors, but such subdivision is attended always with gradual loss of substance.



Reproduction takes place in bacteria, whether by fission or spore formation, with a rapidity bordering on the marvelous. Cohn indulged himself in the pursuit of a calculation of this kind, reaching the conclusion that the progeny of a single bacterium, unchecked in growth, would in the course of three days reach the appalling weight of fifteen million pounds Troy, and in five days fill up a space of 928,000,000 cubic miles, the estimated capacity of the entire ocean. But while some such calculations may be justifiable to convey some adequate idea of the degree to which the earth and the air may be filled in a few days during the prevalence of an epidemic, it must be remembered that it was flights of fancy like these that first brought the germ theory into discredit and derision. Check is put upon the developments and reproduction of all bacteria by the lack of nutrition which sooner or later must ensue, as well as by the inimical action of different varieties upon each other. Thus the bacteria of decomposition cease to multiply, and perish in myriads so soon as the material of their food is converted into inorganic matter; the bacteria of fermentation are destroyed, or their reproduction checked by the alcohol which they form; the bacteria of cholera with desiccation, etc. The bacteria of most diseases perish with the death of their host, as well as from various other causes in life, as by the fever they evoke, or are themselves destroyed by the bacteria of putrefaction.

Thus it has been proposed to cure trachoma with the gonococci of gonorrhœa, lupus and epithelioma with the micrococci of erysipelas, and tuberculosis by the inhalation of the bacteria of putrefaction.—*Dr. J. T. Whittaker, Address in Medicine.*

**INTRAVENOUS SALINE INJECTION IN POST-PARTUM HÆMORRHAGE.**—The value of intravenous saline injection in metrorrhagia is warmly advocated by Dr. F. Weber, in the *St. Petersburg Medicinische Wochenschrift*. Its superiority over transfusion of blood, human or animal, consists partly in the simplicity of the apparatus required. All that is needed is an Esmarch's jar, with a glass

reservoir, a canula, and some India-rubber tubing. The operation is as follows: Five litres of a 6 per cent. solution of common salt is prepared with distilled water of the temperature of the body. If the veins be so collapsed as to be invisible through the skin after ligation of the upper arm, a vein is exposed, and two ligatures passed under the free portion; the distal end is tied, a longitudinal incision is made in the vein, and a glass canula introduced, filled with saline solution, which is then fastened by means of the second ligature. This, and the pressure of the fingers on the vessel, prevent the air from entering the veins. The canula is then connected, by tubing, with the jar containing the whole quantity of the solution. Directly the finger is removed, the injection begins. No ill effects are seen. Dr. Weber relates an instance in which this method is most valuable. He was called by a midwife to a married woman, aged 21, who was seized with *post-partum* hæmorrhage fifteen minutes after the birth of a putrid child. Dr. Weber arrived at 10.30 P. M., an hour after the hæmorrhage had commenced. He found the uterus atonic, reaching to the umbilicus. Message, hot injections, and hypodermic injection of camphor and ether, were used, with some effect. The hæmorrhage returned, he was called at 3 A. M., and after hot douches and ice-tampons, it again decreased; but cerebral anæmia appearing to an alarming extent, and the pulse being imperceptible, hot compresses were placed on the head, the lower extremities bandaged, and hypodermic injections administered every quarter of an hour. These proving unavailing, it was decided to try an intravenous saline injection. This was successfully administered; and when 500 grammes had been given, hæmorrhage ceased, and the patient who had been conscious the whole time, experienced great relief. The pulse, too, became distinct. On 1,000 grammes being injected the patient complained of palpitation, and the jar was lowered in order to lessen the pressure on the circulation. When 1,500 grammes had been injected, the pulse was perfectly good, and the cerebral and hæmorrhage symptoms

disappeared. The patient felt completely invigorated, and took nourishment without vomiting. She continued to do well, and made an excellent recovery.—*British Medical Journal*, May 1, 1886.

### Medical Items.

Dr. Oliver Wendell Holmes took the degree of Doctor of Laws at Cambridge on the 17th instant.

The Chicago Polyclinic, which has now been fully organized, will begin its course of instruction on July 6.

Professor Virchow recently completed the thirtieth year of his occupancy of the chair of Pathological Anatomy at Berlin.

It is stated that there are ten vacancies in the medical corps of the U. S. Navy and that the examination for admission is so severe that applicants are deterred from seeking these positions.

At the annual meeting of the Florida State Medical Association, May 18, 1886, the following officers were elected for the ensuing year: J. W. Porter, of Key West, President; A. W. Knight, of Jacksonville, Secretary; J. D. Fernandez, of Jacksonville, Treasurer.

A legacy of some £15,000 has been left to the Jena University to be applied in zoological research on the basis of Darwin's evolution theory. The testator is Herr Paul von Ritter, of Basle, who believes the teaching of Darwin to be the greatest sign of progress which the century has yet given.—*Lancet*, May 29.

Dr. H. M. Lane, of Carthage, Mo., while on a visit to Rio Janeiro was inoculated by Dr. Freire with the attenuated yellow-fever virus. Dr. Lane thinks it protected from the disease. We learn that some of the culture-fluid employed by Dr. Freire has been placed in the hands of the bacteriologists of Johns Hopkins University.—*Med. Record*.

Another death from rabies of a patient who had been inoculated by Pasteur is announced. The patient was bitten by a mad dog on May 11th, and was inoculated on May 25th. On June 5th evidence of rabies began to appear and on June 7th he died. This makes the eighth death among the patients inoculated by Pasteur, of whom some 950 have been treated thus far.

Dr. Hoedmaker, of Davos Platz, has made numerous observations of the effect of antipyrin on patients with phthisis, and comes to the conclusion that they are more comfortable without it, although it certainly reduces the fever. He states that he has found salicylic acid, especially when combined with arsenic, of the greatest utility in the disease.—*Med. Record*.

A paste for use in eczema; Funk (*Monatsh. f. prakt. Dermat.*, Oct., 1885) recommends the following:

Salicylic acid	-	-	2½ drachms;
Ichthyol	-	-	5 "
Alcohol	-	-	20 "

To be rubbed in thoroughly with a brush twice daily.—*N. Y. Med. Jour.*

The *Journal of the American Medical Association* states that in 1880 the paying membership of the Association was less than 2,000, while now that number is double. "These facts," says our contemporary, "do not afford much support to the idea that the Association is about to crumble to pieces or be speedily succeeded by a Congress of American specialist constructed from a union or confederation of half a dozen American specialist organizations, whose entire membership will hardly number five hundred."

At the recent meeting of the Pennsylvania State Medical Society the following officers were elected for the ensuing year: President, R. Davis, M.D., of Wilkes-Barre; vice-presidents, Hobart Allpart, M.D., of Phillipsburg; Isaac N. Kerlin, M.D., of Elwyn, Delaware County; D. J. McKibben, M.D., of Ashland; and W. B. Lowman, M.D., of Johnstown; judicial council, John H. Packard, M.D., of Philadelphia; John Curwen, M.D., of Warren; and A. H. Schaffer, M.D., of Mifflin.

The Maryland State Lunacy Commission appointed by the Governor, in accordance with an act of the last Legislature, has recently been organized with Dr. A. H. Bayly, of Cambridge, as President, and Dr. Wm. Lee, of Baltimore, as Secretary. The other members of the Commission are Drs. John Morris, C. W. Chancellor, and T. S. Latimer, of Baltimore, and Attorney-General Roberts, of Carroll County. The Secretary is the active member of the Commission and is paid \$1000 a year for his services. He is required to visit the establishments for the insane twice a year, and to make as many other visits as may be necessary, and to report to the Commission. The members of the Commission serve without pay, but are paid the expenses incurred while attending to the business of the Commission.

At the recent meeting of the American Laryngological Association the following officers were elected for 1887: President, Dr. E. Fletcher Ingals, of Chicago; vice-presidents, Dr. E. Carroll Morgan, of Washington, and Dr. J. N. Mackenzie, of Baltimore; secretary and treasurer, Dr. D. Bryson Delavan, of New York; additional member of the council, Dr. F. H. Hooper, of Boston. The following active members were elected: Dr. Benjamin F. Westbrook, of Brooklyn; Dr. Frank Donaldson, Jr., of Baltimore; Dr. Alexander Mac Coy, of Philadelphia; and Dr. J. C. Mulhall, of St. Louis. Professor Ranon de la Sota y Lastra, of Seville, Spain, was elected a Corresponding Fellow. It was decided to hold the next meeting in New York, the time to be decided by the Council.



Original Articles.

AT WHAT PART OF THE INTESTINAL CANAL DO ITS CONTENTS BECOME FECULENT.\*

BY E. G. WATERS, M.D., OF BALTIMORE.

A question that arose incidentally at the last meeting of this Society, viz. : at what part of the intestinal canal the contents become excrementitious or fecal, seemed to me to possess so much interest, as to deserve more than a passing consideration. On this account I have given the subject some examination, and now submit the result to the Society.

Dr. Simon, in his *Animal Chemistry*, edition of 1846, page 574 defines the feces to be "that portion of the food which is not taken up by the absorbents which are everywhere distributed between the stomach and the large intestines, but again discharged from the system." He classifies the insolubles under the heads of vegetable fibres, flesh of old animals, sinews, ligaments, fat, bile modified, biliphæin, cholesterin, mucus, salts, ammonia, magnesian phosphates, etc. We shall find hereafter this list of substances increased or modified in some respects.

Carpenter, in his *Elements*, edition of 1851, page 263, at the close of paragraph 460, says, "During the passage of the alimentary matter along the small intestine, as we shall see hereafter, a large proportion of the fluid is removed by the absorbent power of the villi; and the residue is brought therefore to a more solid consistence. This residue consists in part of those portions of the aliment which are not capable of being dissolved, or finely divided, so as to be received by the absorbents; and in part of the matter poured into the alimentary canal, by the various glands that discharge their contents into it for the purpose of being carried out of the body. The feces, which are thus formed, are propelled through the large intestine by the continued peristaltic action of its

walls, until they arrive at the rectum." Berzelius, as quoted by one of the authors whom I shall cite, puts the waste from the system at twice the amount of the residue from the food in the entire fecal discharge. Again on page 421, paragraph 749 of the same work Carpenter says: "But there is a strong reason to believe that the function of the pyerian glandulæ which beset the walls of the lower part of the intestinal canal, is purely excretory; and that they are destined to eliminate putrescent matters from the blood, and to convey them, by the readiest channel completely out of the body. That the putrescent elements of the feces are not immediately derived from the food taken in, so much as from the secreting action of the intestinal glandulæ, appears from this consideration; that fecal matter is still discharged, even in considerable quantities, long after the intestinal tube has been completely emptied of its alimentary contents." He fortifies this statement by the history of many diseases when food has not been taken for many days, by "colliquative diarrhœas," by spontaneous discharges and those invited by the action of medicine, and by the active efforts of the intestinal glandulæ to get rid of the decomposing elements of the body which precede death from starvation. And this view he again emphasizes, almost in the same words in his *Principles*, edition of 1868, page 132. And again on page 425 of his *Elements*, paragraph 758, the same writer speaking further of the intestinal glandulæ continues, "whose function it is not only to remove the putrescent matter ordinarily formed by the disintegration of the tissues, or by the decomposition of unassimilated food, but also to draw off the still more offensive products of such changes as take place in disease."

"Before the excrementitious matter" says Dunglison, *Human Physiology*, 1850, vol. I. page 616 "reaches the lower portion of the small intestine, it has not the fecal odor, but acquires it after it has remained there for a short time. The brownish-yellow hue becomes deeper; but its consistence, smell and color

\*Read before the Clinical Society of Maryland, May 21, 1886.

vary considerably according to the character of the alimentary matter. \*

\* \* The fecal matter as we find it, consists of the excrementitious part of the food, as well as of the juices of the upper part of the canal that have been subjected to the digestive process. \* \* The peculiar fecal impregnation is probably dependent upon a secretion from appropriate follicles—those of Peyer, for example, and we can thus understand \* \* \* why fecal evacuations may exist when the individual has not eaten for sometime, or taken but little nourishment."

Müller Elements of Physiology, 1843, page 402, says, "The mixture of chyme, mucus, bile, and pancreatic juice becomes in its passage through the lower part of the small intestine more consistent and of darker color. The fluid parts are absorbed by the lacteals. All the solid matters, as mucus, skins of fruits, woody fibres, hairy matter and resin, on reaching the lower extremity of the intestine constitute the excrement from which, however, the fluid ingredients continue to be absorbed during its passage through the large intestine."

Kirke and Paget in their Manual of Physiology, 1853, page 203, say, "Its result (absorption) is that the mixture of chyme and various secretions is generally made more consistent and darker, and at the lower end of the small intestine contains little more than the insoluble and indigestible matters, such as starch, woody fibre, hairy matter, epithelium cells and mucus corpuscles, epidermis of both vegetable and animal tissue, crystals of ammonia, magnesian phosphates and other salts, the coloring and fatty matters of the bile and other excrementitious substances."

Dr. John William Draper, *præclarum nomen* in Medical Sciences, in his Human Physiology, 1856, page 83, writes as follows: "As the digested mass passes onward \* \* \* it becomes of a more solid consistency as the absorbents gradually remove its liquid portions. \* \* \* From Peyer's glands a secretion has exuded which perhaps gives to the mass the characteristic odor it is now

assuming, it indeed these organs are not connected with absorption. The excrementitious remains are colored yellow by the coloring matter of the bile, and are partly derived from the undigested residue of the food and partly from the decay of the system itself."

Dalton, in his Human Physiology, 1861, pages 142-3, says, "Digestion of food goes on continuously through the small intestines, producing three different substances. 1st. Albuminose, from action of gastric juice on albuminoid matter. 2d. Emulsion, from pancreatic juice on fat. 3d. Sugar, from starch acted on by mixed intestinal fluids. These products of digestion are removed from the tract by the absorbents. Below the ileo-cæcal valve the contents change in their odor, color, and consistency. This portion of the intestinal contents, or the feces are not composed, for the most part, of the undigested remains of food, but of animal substances excreted by the mucus membrane of the large intestine." This writer calls attention to the fact that Dr. Marcet found the most important constituent in the large intestine be excretine. It will be observed that Dr. Dalton ignores entirely the residuum of the food, together with the glandular and follicular excretions that exist in such abundance in the ileum and escape from it through the ileo-cæcal valve, as contributing largely to the contents of the large intestine.

Carpenter in his Principles, edition 1868, page 131, says, "Although it cannot be stated with certainty what is the precise portion of the glandular apparatus connected with the intestinal canal which is concerned in the elimination of that peculiarly putrescent matter which gives to feces their characteristic odor, yet it may be stated, almost with certainty that this matter is not derived from the decomposition of the undigested residue of the food." And page 132 of the same book he quotes Liebig's experiments to the effect that albuminous matters heated with solid hydrate of potash, the heat being continued until most of the nitrogen is driven off as ammonia, and hydrogen begins to be given off, the residue being super-satura-



ted with dilute sulphuric acid and then distilled, yields a liquid containing acetic and butyric acids, and possessing in an intense degree the characteristic odor of feces. "As the action of caustic potash at high temperature is simply a limited or incomplete oxidation or combustion, this curious result confirms the view that had previously been put forth by Professor Liebig, that the proper fecal matter is the product of the imperfect oxidation which a portion of the histogenetic constituents of the food undergo the course of their retrograde metamorphosis, being comparable to the soot or lamp-black of a furnace or lamp." It is further remarked that this odor disappears on exposure to the air and complete oxidation.

Dr. Reese, in his *Analysis of Physiology*, 1852, pages 205-6, states that, "The function of the glands of Brunner and Peyer not perfectly known, but there is a strong reason for belief that it is purely one of excretion. \* \* No doubt much of the fecal matter is derived from these glands, for we see it discharged from the bowels when no food has been taken." Flint in his *Physiology of Man*, 1868, regards stercorine and excretine as giving to the feces their distinguishing characteristics. The first was recognized by Baudet in 1833, in the serum of the blood, and by him called seratine. Flint considers it as the changed condition of cholesterine, and claims to have discovered it in the feces in 1862.

Foster, one of the latest and most exhaustive writers on this subject, in his *Text Book*, 1880, pages 314, 15, 16, says: "These products, (fats, sugar, peptones, lactic acid, &c.) as they are formed, pass either into the lacteals or the portal blood-vessels, so that the contents of the small intestine, by the time they reach the ileo-cæcal valve are largely, but by no means wholly deprived of their nutritious constituents. \* \* \* We have already seen that during artificial pancreatic digestion a distinctly fecal odor, due to the presence of indol, is generated, and the fact that the presence of bacteria or other similar organisms is essential to the presence of this body does not preclude the possibility of it,

with its derivations, being the chief cause of the natural odor of feces, for undoubtedly bacteria may exist throughout the whole length of the intestinal canal. At the same time, it is quite possible, if not probable, that specific odoriferous substances may be secreted directly from the intestinal wall, especially from that of the large intestine. Birger finds indol and skatol, the latter in large quantity, in excrement." Nevertheless, on page 314 of the same volume, Foster seems to cancel one of his most important inferences in the above quotation, for he says: "Whether digestion properly so called, is all but complete at the ileo-cæcal valve, or whether important changes await the chyme in the large intestine, the chief characteristic of the work done in the colon is absorption." If this be true, the secretive functions of the mucous surface of that intestine must be suspended for the most part during the passage of the contents of the canal through it.

In the *American Journal of the Medical Sciences* for July, 1860, page 217, *et seq.*, will be found an analysis of a most interesting case of intestinal fistula reported by Prof. Busch, of Bonn. It was that of a woman, aged 31, who had been gored by a bull. An opening subsequently took place in the "upper third of the small intestine, [Foster says in the duodenum, but this is not stated in the analysis, but, on the contrary, contraindicated]\* which remained permanent. The opening was about one and one-fifth inches in length. and through it escaped, and were received for examination, matters that had come through the pylorus, and into it were introduced many forms of aliment

\*NOTE.—The fistulous opening in this woman's belly was in the median line, and between the naval and pubis. A great opportunity seems to have been lost by Professor Busch in his experiments with this person. Had the food that had passed through the stomach, upon its emergence at the fistulous orifice been again introduced into the lower part of the opening and thus been subjected to the action of the intestinal juices through the entire length of the canal, this question might have been solved, and placed beyond future cavil. This simple and obvious way of determining the matter seems never to have been suggested to the mind of the experimenter.

designed to be subjected to the action of the intestinal juices in the lower part of the canal. Among the many points of interest in this case, I note three which are especially pertinent to the subject of this paper. 1st, on numerous occasions articles of food that were distinctly recognizable, made their appearance at the upper orifice in from fifteen to twenty minutes after being swallowed; 2nd, a reversed peristaltic action at times brought back to the opening various aliments after the expiration of several hours from the time they had been introduced into the lower part of the bowel. And 3d, there is no mention whatever of a fecal odor to the dejections. A highly offensive and putrid odor is noted as pertaining to the dejections in several cases, but in no instance, that I recall, was the fecal odor distinguished in them. It should be remembered that in no case did food, after being swallowed, pass beyond this opening.

Now, the sum of this whole matter is this, that here, as in so many departments of physical study, our ignorance is humiliating, after the immense time and labor given to the subject by able and conscientious men who were and are not mere makers of books. Nevertheless, the weight of evidence is largely in favor of the supposition that the contents of the small intestine before they are pushed beyond the ileo-cæcal valve are probably, as a rule, wanting in no feculent feature, unless it be that of mere solidity. If the contents of the small intestine are not excrementitious, how is it that in stercoraceous vomiting such matters are brought up, if, as some experimentists tell us, the ileo-cæcal valve is impervious to the return even of liquids from beyond it? And if the chief office of the colon is absorption, according to Foster, how does so considerable an accumulation of feculent matter take place in it, when we remember that Berzelius estimates the residue from food at less than 33 per cent. of the entire mass? To these and other similar questions it seems to me there can be but one answer.

### Society Reports.

#### THE CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAY 21st, 1886.

Under the head of reading papers :

*Dr. George H. Rohé* read a paper on

#### THE PRESENT STATE OF THE DOCTRINE OF PARASITICISM IN DERMATOLOGY.

He reviewed the clinical and experimental evidence on the question and concluded that the following skin diseases are demonstrably of parasitic origin. Favus, ringworm, chloasma, erysipelas, leprosy and glanders. Other diseases that are sometimes considered as due to parasites, but in which the etiological relations of parasitic fungi or bacteria must be regarded as unproven are boils, carbuncles, impetigo contagiosa, rhinoscleroma, pityriasis capitis, alopecia areata, psoriasis, lichen ruber, mal de los pintos, mycetoma, lupus and verrugas. Dr. Rohé thinks that although in the latter the proof is not complete, an affirmative demonstration is probable.

*Dr. I. E. Atkinson* wishes to disclaim any credit for the work upon the bacillus of leprosy referred to by Dr. Rohé. The work was the result of Dr. Berman's labors and Dr. Atkinson simply demonstrated the specimens for Dr. Berman, who was unable to attend the meeting of the American Dermatological Association held at Newport. He was very much interested in Dr. Rohé's paper. He considers mycosis fungoides as beyond a doubt proved to be the result of the presence of a streptococcus. As to lupus the evidence varies, some observers claim to find the bacilli in small numbers while others fail to find them at all. Don't think the evidence sufficient to justify us in classing it as a disease due to the presence of the tubercle bacillus. He referred to a certain wart formation recently described and grouped with the infectious granulomata under the name of *verruca necrogenica* as being claimed to result from the local deposition of the tubercle bacilli. They



occur usually at the point of wounds received while dissecting the bodies of patients dead of tuberculosis. He thinks it singularly at variance the one with the other, that if the localized deposit of tubercle bacilli should in one case produce lupus, that it should in another instance give rise to a wart. As to the late work of Lustgarten on syphilitic new-formations, while he don't think it proven, yet he thinks the probabilities are in favor of its correctness. At all events, it presents many interesting propositions.

*Dr. G. M. Sternberg* said as to the local expression of tuberculosis, we commonly see tuberculous joint troubles in children from which they make complete recovery. Cold abscesses he considers another example. Thinks the etiological value of micrococci in pus proven.

*Dr. E. G. Waters* read a paper entitled

AT WHAT POINT IN THE INTESTINAL CANAL  
DO ITS CONTENTS BECOME FECULENT.\*

#### DISCUSSION.

*Dr. J. H. Branham* don't think a Peyer's patch a secreting body but rather an absorbing gland and takes it to be a member of the lymphatic system.

*Dr. N. G. Keirle* thinks it difficult to say at an autopsy at what point in the canal the contents become feces, either by their odor or by their appearance.

TUBERCULOSIS OF THE RETRO-PERITONEAL  
GLANDS.

*Dr. Keirle* exhibited a specimen that he had finally decided to be a tuberculosis of the mesenteric glands. His opinion had wavered between a syphilitic adenitis and a sarcomatous process and tuberculosis.

*Dr. I. E. Atkinson* referring to the enormous glandular enlargements, seen in primary syphilis in negroes, said that he took it to be rather a peri-adenitis than a proliferation of the gland elements themselves.

*Dr. J. H. Branham* asked if in scrofulous negroes suffering from syphilis

were the tubercle bacilli always found in the enlarged and caseous lymphatic glands.

*Dr. A. C. Abbott* replied that while it was generally admitted that the glandular enlargements with caseations seen in scrofulous subjects were the result of a tubercular process, yet it could not be said that microscopic examination always revealed the tubercle bacilli. The reason for this rests in the fact that they are here most probably in the spore stage, and as we have no staining reagents that will satisfactorily demonstrate spores, we must resort to cultivation and inoculation experiments for their positive demonstration.

DEATH FOLLOWING FRACTURE OF THE  
CRANIUM.

*Dr. N. G. Keirle* related a case of a man who after having fallen upon the back of his head went about for eight days, when he died. At times he was more or less irrational. Autopsy revealed fracture of the orbital plate on the right side and another fracture in the occipito-temporal region on the left side. These fractures were not continuous with one another.

*Dr. L. McLane Tiffany* said the fracture of the orbital plate was probably the result of counter stroke. He cited the case of President Lincoln who was shot in the back of the head on the left side and sustained a counter stroke fracture of the orbital plate on the right side. He demonstrated the physical principles involved in fracture by counter stroke. He said that fracture of the orbital plate is most often the result of counter stroke.

*Dr. W. D. Booker* related the case of a colored boy who had been kicked in the face by a horse. There was fracture of the frontal bone. A bit of the outer table was driven into the frontal fossa. On the following day a bit of bone was removed that looked like orbital plate and a week later another portion came away. The left eye was enormously bulged out and there was blood behind the conjunctiva. The eye was removed, the wound healed and the boy is now doing well.

\*See page 161.

# TRANSACTIONS OF THE CHICAGO GYNÆCOLOGICAL SOCIETY.

STATED MEETING APRIL 23, 1886.

The President, DANIEL T. NELSON, M.D., in the Chair.

## REPORT OF CASE OF HERNIA OF THE UMBILICAL CORD.

*Dr. Charles Caldwell* read a paper with the above title.

I was called August 10th, 1886, at 6 P. M., to attend Mrs. C., who was in labor with her ninth child. I made an examination and found a vertex presentation, first position; os well dilated but no bag of waters had formed.

The first stage of labor was completed at 7 P. M., and the second an hour later. The child, a female, was quite large with very broad shoulders, which were difficult to deliver. As soon as the child was expelled, I discovered she had a large umbilical hernia. I ligated the cord and gave the child to the nurse, who removed it to another room, that the mother might not be alarmed at sight of the tumor.

The placenta was expelled by Credé's method and the uterus contracted firmly under pressure of the left hand.

After the binder was applied and the mother made comfortable, I examined the tumor more carefully. It was as large as a small orange and of similar shape. The circumference in the largest place,—the center,—was about ten inches. The diameter of the orifice or abdominal opening two inches. The sac was translucent and the viscera,—intestines,—could be distinctly seen when the child cried and forced them out. The umbilical vessels were on the left side of the sac. The skin was projected from the abdomen on to the side of the sac at its base about half an inch.

*Diagnosis.*—Hernia of the umbilical cord.

*Pathology.*—Ectopia of some or all of the abdominal viscera at the point of insertion of the umbilical cord, is usually due to an arrest of development of the

abdominal parietes, and failure of the intestines originally projecting into the vitelline duct to turn into the abdominal cavity.

Simpson thinks it may sometimes be traced to peritonitis. Cleft abdominal walls, a similar arrest of development to that of cleft sternum, may exist in the muscular structure of the front of the abdomen, which may expose the whole contents of the abdomen, or the central line of the abdomen may be weak from deficiency of muscular structure.

If the orifice is very small, it can be treated successfully by a simple compress and adhesive straps. But if large, nothing except a plastic operation is indicated.

The coverings of the hernial sac are, from without inwards (a) amnion, (b) peritoneum.

*Treatment.*—After examining the sac thoroughly I was convinced that nothing but surgical interference could save the child's life.

I called our President and Dr. Jaggard by telephone, but both were too busy to assist me that night. They both recommended a cork compress held in position by adhesive straps, evidently thinking it an ordinary case of umbilical hernia.

I decided not to operate until the next day, and enveloped the sac with absorbent cotton, retaining it in place with a loose band.

The next afternoon, Drs. Dudley and Jaggard met me in consultation. After examining the little patient, they decided with me, that nothing but surgical interference would give her any chance of life, and kindly assisted me in the operation.

It was decided not to give an anæsthetic. Dr. Jaggard seizing the sac, gently forced its contents, the viscera, back into the abdominal cavity and I ligatured it as close to the abdomen as possible, but did not draw the ligature perfectly tight. At the suggestion of Dr. Dudley the sac was now opened, to be sure no portion or loop of the bowel was confined by the ligature.

The peritoneum being opened, the index finger was passed into the abdomin-



al cavity to hold back the bowel and protect it from the points of the hare-lip pins, which were passed at right angles to each other through the narrow piece of skin at the base of the sac. Two more ligatures, carbolized silk, were applied beneath the pins and were drawn tight enough to close the opening. The outer layer of the sac was trimmed off leaving a stump one and a half inches long. Dr. Dudley passed a gathering suture round the stump sealing it more tightly. This completed the operation; after which the stump was dressed with iodoform,—a narrow strip of carbolized gauze passed beneath the pins,—several layers of absorbent cotton and a roller bandage. The child was restless that night, crying several times, but slept well the next day. I dressed the stump every day, reapplying a similar dressing. The bowels moved naturally until the 16th, when I discovered some faecal matter on the dressing as I removed it.

On the 17th, all the faeces passed through the fistulous opening. The members of the family were very much alarmed and wished me to close the opening at once. I assured them that nature would close it without any further surgical interference.

I called on Dr. C. T. Parkes for his advice. After hearing the history of the case he said it would undoubtedly close by granulation in a few days.

For four days all the faeces passed by the fistulous opening, but on the fifth there was a little stain on the diaper. On the sixth more, and on the seventh all the faeces passed *per rectum*.

The family were happy once more, for the fistula had closed. There were no symptoms of peritonitis at any time. Neither vomiting, tympanites nor pain. The patient did not cry more than babies generally do, but nursed and slept nicely, requiring no unusual care.

The bowel, at point of perforation, was held firmly bound to the abdominal walls by lymph, which was thrown out.

From this time the wound healed very rapidly. The end of the stump sloughed, leaving it quite short. The small intestine was probably the one

perforated, for there was no odor to the discharges.

What caused the rupture of the bowel to take place I am unable to say. Probably, either a portion of the bowel was caught, and became strangulated by the ligature, or it was punctured by a pin, as that instrument was inserted.

Dr. Dudley says the surgical operation was certainly a laparotomy, for the abdominal cavity was opened and the index finger introduced.

#### DISCUSSION.

*Dr. De Laskie Miller* said he had seen numerous cases of hernia but thought this specimen was possibly more extreme than any he had seen.

*The President* asked Dr. Miller in how large a hernia he would deem operative procedure, of a plastic nature, necessary.

*Dr. Miller* did not think it possible to state, by actual measurement; so much depends upon the condition of the tissues surrounding the opening, that the absolute diameter of the opening would not be the governing principle. If the borders of the opening are of considerable thickness and the tissues well developed, it would be possible to reduce and probably cure a hernia independently of any cutting operation. He inferred that in the case described in the paper there was a deficiency of all the tissues except the peritoneum and the amnion, the skin projecting upon the sac one-half inch around the opening. He thought there was another explanation possible in this case, viz., that the duct leading from the umbilical vesicle remained or became patulous and the faecal matter passed out through that; for the duct can be seen in the cord, even at delivery, in some cases. He inquired as to the cause of the arrest of development of the abdominal parietes in such a case.

*Dr. Edward Warren Sawyer* thought it not a very unusual thing to find a prolongation of the intestine into the cord. He once came very near tying the cord including a loop of intestine, so near that he had since observed the rule to always satisfy himself, by careful manip-

ulation of the cord, that contained no loop of intestine, and this routine practice had revealed the fact that very often a suspicious enlargement of the cord is found, sometimes extending three-fourths of an inch above the level of the abdominal wall and the intestine, or portion of the omentum, is not infrequently projected into this *cul de sac*. He thought in the majority of case nature would take care of the condition without any care from the attendant. He had never seen as large a hernia as that described by Dr. Caldwell, and did not understand why it should have assumed a spherical shape; he could understand how it might be pyriform or sausage-shaped, and extend an inch or two into the cord, but how the cord could suddenly dilate and form a large globe, and this globe be followed with the contents of the abdomen, it was difficult to comprehend.

Dr. Sawyer inquired what there was about this case that enabled the physicians to decide so quickly that an operation must be resorted to in order to save the child's life. To him an operation would have been a second consideration. Dr. Jaggard evidently reduced the hernia without difficulty, and having reduced it, it seemed to Dr. Sawyer that a well applied bandage would have secured it. The operation was brilliant and creditable, but he thought an operation should have been considered, after they had failed utterly to secure the hernia within the cavity by a well applied bandage.

It was stated in reply to questions that the child presented no symptoms; the hernia was reduced by Dr. Jaggard; the tumor about the size and shape of an orange; the operation was performed the day after birth; there was no evidence of strangulation of the gut.

Dr. Sawyer said that Dr. Caldwell had assured him that he was certain that in passing the hair-lip pins no part of the intestines was included, and the finger was introduced to push everything beyond the reach of the pin. Dr. Sawyer thought, however, that the centrifugal pressure must have been considerable, and the contact quite severe. He thought it strange that none of the fecal

matter escaped into the peritoneal cavity, although there were adhesions between the intestine and the abdominal parietes.

*The President*: Of course every case must be decided on its merits, but might we hope for the closure of the opening of an inch and a half in diameter, provided the tissues are well developed around it, without a cutting operation? It would seem possible to close as large an opening as in the case under discussion by simple adhesive strips. He had seen one case that reminded him of this: the opening was not nearly as large, it did not exceed three-fourths of an inch in diameter, and the length of the sac was much longer than the opening. Into this sac there was projected a solid body. As the child afterwards died, he found it was the *lobus Spigelii* of the liver. It was so conical or heart-shaped, that the anatomy could not be made out until after death. The instruction to him in that case was the importance of not including any of the abdominal tissues by the ligature that might be passed around. He was careful to pass the ligature around the umbilical cord so as not to include the sac, but it might readily have been passed close to the abdomen and made to include the solid tissue, which, as he afterwards found, was a portion of the liver. The child died, not from the hernia, but from some want of development which he was unable to find out, no careful *post mortem* examination being allowed, but he believed there was lack of foetal development necessary to life. The child was fairly well developed and seemed as if it should have lived, so far as this slight defect was concerned.

The President asked if anyone could suggest the reason for the fecal fistula. It seemed to him that in this case it was the result of inflammation caused either by pressure against the pins, or the ligature; if the intestinal wall had been punctured by the pins, the physician would have seen evidences of it earlier.

Dr. J. H. Etheridge inquired whether this was not the youngest laparotomy on record. He wished to know if it would not be possible to crowd back the viscera and then hold them in place with adhesive strips.



*Dr. T. D. Fitch* said that he had not had experience with congenital hernia at birth, but had seen it occur within twenty-four hours afterward, and had successfully closed an opening an inch or inch and a quarter in diameter by the ordinary method, viz.—Compress and bandage.

*Dr. Fitch* had had very peculiar success in the treatment of infantile umbilical hernia, by the ordinary means, and he should hesitate very long about an operation until he had tried all the ordinary means. His method of treatment differed somewhat from the ordinary treatment, however, in the adoption of an elastic web bandage instead of the ordinary bandage or adhesive plaster, and he thought it far superior to an inelastic bandage, as it gave the child room for an accumulation of intestinal gases, which very often become painful when a fixed bandage is placed around the abdomen. He first applied a hard compress, like a button mole—(plano-convex)—to cover the opening. This should be large enough to extend three-eighths of inch beyond the margin of the opening, and should be covered with one or two thicknesses of fine soft muslin. After returning the protruded substance *perfectly*, the compress should be fixed in position by short adhesive strips, then apply the elastic webbing around the body of the child tolerably tight and let each turn of the bandage lap the previous one-half its width, making a sufficient number of turns to cover six or eight inches of the abdominal surface vertically. He would leave this on, undisturbed, unless the child became restless, or exhibited some indication of injury—for a month or longer before removing it. He had never found that the skin suffered from the confinement of the perspiration.

Another advantage was that the elastic webbing being rough and the laps of the bandage holding each other, it always stayed in place, and held the button firmly and so secured the opening against any possibility of protrusion. He had used this method successfully for about thirty years. He had a case at Waukegan which occurred twenty-

four hours after birth; did not attend the mother at the birth, but was called to treat the hernia which was reducible, and would gurgle in and out at almost every respiration, bulging out as large as an English walnut. He visited the child only once and told the parents to remove the bandage at the end of four weeks, when the opening was found entirely closed. The child is now nine or ten years old, perfectly healthy and always has been.

*Dr. Charles Caldwell*: The Fellows of the Society have evidently misunderstood the nature of the case described in the paper. I am sorry that such obscure and confused conceptions have been conveyed. The case was one of hernia of the umbilical cord, consisting in "the escape from the abdomen, at the point of insertion of the cord," of some of the foetal abdominal viscera, and was due either "to arrested embryonic development preventing the complete closure of the abdominal cavity or failure of the foetal intestines, originally situated outside the abdomen, to enter the same" (Lusk). The remarks of most of the Fellows are accordingly irrelevant.

As no one who has witnessed the operation was present at the discussion of my paper, several questions were unanswered.

*Dr. Sawyer* wished to know why we decided so quickly that surgical interference was necessary to save the child's life?

The consultation was held about twenty hours after the birth of the child, and at that time the outer layer of the sac, the amnion, was dark and gangrenous in several spots. Its nutrition was cut off when the cord with its umbilical vessels was ligated, and it would have sloughed off in a few days leaving the viscera covered by the peritoneum only. We were of the opinion that such a condition as then existed would be followed by general peritonitis and death without some surgical operation.

*Dr. Byford* wished to know the literature of the subject. I have been able to find but one case similar to mine.

Thomas Bryant, in the last edition of his Surgery, mentions the only case he ever saw and his treatment. In June, 1876, a child, one day old, was brought to him with hernia of the cord. The sac was translucent, the size of a small egg, and contained the cæcum and vermiform appendix. He pressed back the bowel with the thumb and forefinger, stitched up the cord at the umbilical orifice with deep sutures and ligatured the cord itself at the apex of the congenital hernial sac.

Recovery was complete without a single bad symptom. He recommends his operation in all similar cases, evidently considering it the only treatment indicated. So we were supported by the best of authority, in operating instead of trying to apply a compress. Should I ever meet with a similar case, I would perform an operation different from either Bryant's or mine.

I would first remove the amniotic layer of the sac, if it could be separated from the peritoneum, excising or amputating it at its junction with the skin, return the viscera and peritoneal sac to the abdominal cavity and close the abdominal opening as in a case of exploratory incision, or simple laparotomy, either incising the peritoneal sac to better protect the bowels from needle points, or stitch to the bottom of the wound by deep sutures, and support the sutures by adhesive straps around the abdomen.

I would recommend this operation after observing how quickly the amnion sloughed away. It might just as well be removed at once if it can be easily separated from the peritoneum.

AN APPLICATION TO PREVENT SCAR-  
RING AFTER VARIOLA. — Reimer (*St. Petersburg med. Woch.*, No. 20, 1885) speaks highly of the following salve, originally suggested by Schwimmer:

Carbolic acid - 30 to 80 grains;  
Olive-oil - - - 5 drachms;  
Powdered chalk - 1 ounce.

Apply on a linen cloth, to be renewed twice daily. In thirteen hundred cases in which this ointment was used, deep scars were not once observed. — *N. Y. Medical Journal*.

## SANITARY CONVENTION AT KALAMAZOO, MICHIGAN.

(Specially Reported for the *Maryland Med. Jour.*)

The Kalamazoo Sanitary Convention, under the auspices of the Michigan State Board of Health, held its sessions June 1 and 2, 1886. The State Board of Health was represented by Prof. Victor C. Vaughan, of Ann Arbor; Dr. John H. Kellogg, of Battle Creek, and Dr. Henry B. Baker, of Lansing.

After the address by the mayor of the city, Hon. Peyton Ramney, and the address by the President of the Convention, Hon. H. F. Severens, Dr. H. H. Schaberg, health officer of Kalamazoo township, read a paper on

### DISEASES OF POVERTY.

The diseases incident to poverty include among their causes mal-nutrition, insufficient or improper clothing, and the bad hygiene of poorly built, unhealthy dwellings. The terrible results of deficient or improper nutrition are found in the infants of the poor. It virtually kills the child in many cases. How can an infant's weak organs assimilate the improper food thrust on it? The mother, weakened and harassed by lack of food, and prematurely broken down by overwork, is unable to give a child a good constitution. And when the natural food of the infant is supplemented by unfit food, from other sources its life is stopped by terrible suffering. Indigestible food causes many untimely deaths, killing more human beings than all other causes. Insufficient or improper clothing is also a great evil, too warm in summer, too cool in winter, causing the child to become stunted or dwarfed. Ignorance kills rich and poor. Poverty often debases by stunting the sensibilities, destroying the sense of cleanliness by close quarters and lack of means for cleanliness. Despair, discouragement, and surrender to these circumstances follow. Filth does not start a contagion, but it causes it to become more virulent and prolific. The physician in such cases has to battle against ignorance, obstinacy and resentment,



where the case needs the most favoring circumstances. It has to be treated and checked where the family live, in one or two rooms, with no ventilation, over a poisoned cellar or soil that is a death-trap. The doctor cited a case in his practice of obstinate disease that was finally overcome by simply moving the patient to wholesome air. He noted particularly one local cause of ill-health, in the practice of girls working in the celery gardens in the late fall, doing themselves great mischief by keeping their hands in the cold water washing celery for market, sowing the seeds for much future evil.

#### SANITARY REGULATIONS OF THE HEBREWS,

was the subject of a paper by Rabbi Ignatz Mueller, of Kalamazoo. He showed the growth of interest in sanitary regulations to the present day, and emphasized the misery produced by ignorance. Hatred against the Jews had kept the knowledge of their sanitation from the world. Two principles stand out prominent in the Jewish regulations. The Hebrews insisted on cleanliness and temperance. Cleanliness was the first condition of health, and the discrimination between clean and unclean food was shown by the Rabbi by frequent scriptural quotations. The regulations concerning food were supplemented by those concerning conjugal life and purity. Violation of marriage vows was punished with death. Sanitary activity extended over both public and private interests. The dead were decently buried though they were friendless. The principle of temperance was no less carefully observed. The Mosaic code did not favor asceticism or austere abstemiousness. The use of wine was allowed. It is an error that the Jews do not and did not use fermented wine on the feast of the Passover. Wine is not wine unless fermented. Hebrew and Greek passages were cited in proof of this. Indeed, there would be no merit in the moderate use of that which cannot intoxicate. A Talmudic fable illustrated Satan's use of wine and the abuse frequently made of wine. Intemperance was strictly for-

bidden by the Jewish code, and most impressive words are used against it as the source of crime and degeneration. The intemperate and gluttons were punished by being stoned to death publicly. (Deut., 21: 18-21). And this very thing had such a great influence upon the Jews, that not only as the Talmud says, was this law never enforced, but is it not true, even now-a-days, that one rarely finds any drunkards among Jews. Now you see a striking resemblance between our modern sanitary provisions and those prescribed by the Mosaic code. But we see, at the same time, while our modern sanitary regulations do not interfere with the habits and manners of the individual life, the Mosaic law draws even these into the sphere of its codification, and regulates them without encroachment on the value of individual freedom.

In the first evening session, Mr. Frank Wells, of Lansing, Michigan, read a paper on

#### HISTORY OF INVESTIGATIONS CONCERNING MICRO-ORGANISMS, AND THE GERM THEORY OF DISEASE.

Everything is filled with these minute beings. These spirits of the air are ever contending for an existence, the life germs and the death germs. The old theory that decay is a process of oxidation has given way to the new one that this process is caused by living organisms, which cause apples to decay, eggs to become addled, and yeast and other things to ferment. The paper described the long contest between the disciples of Darwin and their opponents whether there was such a thing as spontaneous generation of life, or the apparent evidences of this were merely produced by organisms contained in the air and other mediums. The history of science, the speaker remarked, was a history of the overthrow of beliefs, and such was the fate of the theory of spontaneous generation. The struggle between these two theories passed through an eventful course. One young chemist, Louis Pasteur, doubted the efficiency of the tests that had been relied on to prove spontaneous generation, and pro-

duced experiments that for a time settled the matter. A rival inclosed a wisp of hay in a receptacle filled with artificial air, the air having been submerged in mercury, which was assumed to cut off all trace of living organisms, and succeeded in showing the development of life in the hay after those close precautions. Pasteur, however, reversed the conclusions of the demonstration by showing that mercury itself was a medium for carrying the organisms and must have supplied such to the hay. He then procured air from different localities where the atmosphere was little laden with germs. Those which were freest were from up on the Jura and were taken from the stratum of a strong wind in the high atmosphere. With these specimens of air that were shown to be in most cases wholly free from organisms he showed that the union of air with putrescible liquids did not produce animalculæ. Tyndall's tests, showing that the clearing of the air, by passing it through flame, demonstrated the material to be organic matter, and his final and conclusive tests with test tubes in an isolated chamber, putting an end to all further dispute, were also described.

The similarity of certain contagions to fermentation early led to a suspicion of the germ theory of disease. The paper described one of the earlier demonstrations in a particular class, the near annihilation of the silk-worm industry in France, and loss of \$20,000,000 a year; the appeal to Pasteur to investigate, and his almost instant discovery that the disease was caused by a minute organism, and the complete remedy he suggested in having the silk-work raised from eggs free from the infection. His experiments in identifying the cause of splenic fever in sheep and cattle, and chicken-cholera in fowls, and demonstration of a remedy in vaccination were also described. His experiments showed that the virus could be used to protect against itself, going so far as to silence all doubters. Lister showed that bad results of surgical operations were due in great part to microbes. Dr. Koch made the discovery that consumption was due to bacilli, which seized on peo-

ple predisposed to it. The saliva and fluids of the alimentary canal furnish a medium for the disease germs. The cholera bacillus was soon afterwards discovered. The possibility of vaccination as a preventive was foreshadowed. Those organisms were found to be enormously productive, multiplying to the extent of 16,000,000 for 1 in 24 hours. The paper also described the more recent experiments of Pasteur on rabies; the inoculation of a rabbit by trepanning its brain and infecting it with the virus; then transmitting it from one rabbit to another through a long series till the virus was attenuated, and could safely be used for inoculation.

#### DISINFECTION.

Professor Victor C. Vaughan, M.D., Ph. D., member of the State Board of Health, delivered an address on Disinfection. It is the office of disinfection to destroy the germs described by Mr. Wells' paper. The difference between disinfection and antiseptic properties must be kept in mind, the agency of the latter being to retard decay. A common instance is the use of salt; another that of smoking meats to preserve them, the creosote of the smoke being the active agent. A disinfectant is a germicide and many of these germs can be killed if we can find out where they live. Germs multiply by a process of dividing themselves or through spores, analogous to seeds. Disinfectants are of two classes, as they destroy the germs themselves or their seeds. Fire is one of the best disinfectants. Steam is next to fire. When heated to the degree required for twenty-five pounds pressure it is very valuable and can be applied to articles through the medium of a tight box. It is impossible to disinfect a room while occupied by human beings. Among the common disinfectants a good one is corrosive sublimate, using two ounces of the solution, to a gallon of water. Chloride of lime, eight ounces of the solution to a gallon of water, is good, but does not want to be placed in a saucer; put a quart of it in the commode that receives the excreta. The burning



of sulphur to purify a room, as after diphtheria, is effective. The room should be made tight. Use three pounds of sulphur to every 1,000 cubic feet of room space. The room can be opened and aired after twelve hours. Professor Vaughan also dwelt on the means taken by physicians and nurses to prevent taking a contagion or carrying it in their clothing.

*Second Day.*

THE SANITARY ASPECTS OF THE PROPOSED  
STRAIGHTENING OF THE KALAMAZOO  
RIVER,

by George S. Pierson, City Engineer of Kalamazoo, was purely of local interest.

HEALTHY HOMES.

Healthy Homes by Professor Victor C. Vaughan, of Ann Arbor, was devoted mainly to the homes of the working classes, but the principles stated were of interest to all classes. A cottage may be as healthy as a palace, but it must stand on soil in which there is no animal, and not much vegetable, matter. A house on damp ground breeds consumption. A layer of cement, impermeable by gasses, should be placed beneath the floor. The cellar should have windows hung on hinges, kept open when practicable. Use no arsenical wall paper. A good druggist can make the arsenic test at small expense. Make the floor of hard wood, and have tight joints. Rugs are preferable to carpets. Do not shut out the sun; faded carpets are not so bad as faded cheeks. Have the living rooms on the sunny side of the house. The kitchen is the most important room in the house; if it is filthy and unhealthy, all also is vain. It should have a window on two sides, and an independent ventilating shaft. Have both window sashes movable in all the rooms. Houses built without ventilation can be partially ventilated by a short board, setting under the lower sash, leaving a space where the sashes join. A room heated by a stove can have a good air supply brought into the room by a pipe, open-

ing into a jacket around the stove. Ventilation can be had by a pipe leading from near the floor to the chimney but a chimney should have one flue for smoke and another for foul air. Water is a great source of disease. When a cistern is filled from the roof it should be arranged so that the first washings of the roof in a storm can be turned off from the cistern. Build the cistern so that the soakage from the surrounding surface is impossible. With regard to the disposition of excreta the professor preferred the dry earth system, the accumulations being removed semi-monthly. It cost less than \$5 a year and does not admit of contamination. Garbage should be burned. Cesspools should be water-tight, ventilated and emptied once a month.

A paper on

SANITARY CONDITION OF PUBLIC BUILDINGS  
IN KALAMAZOO,

was read by Dr. John H. Kellogg, of Battle Creek, member of the State Board of Health. He had made a personal examination of the churches, jail and school buildings of Kalamazoo in regard to their heating and ventilation. The paper was of general as well as of great local interest. Besides a description of the needs of the several buildings examined, he gave a good outline of the principles of heating and ventilation. He was followed, by Dr. C. B. Cornell, on

NEED OF A PUBLIC HOSPITAL IN KALAMAZOO.

In the last session of the convention, there were three papers on

PERSONAL DUTY OF THE CITIZENS TOUCHING  
THE PREVENTION AND SPREADING OF  
COMMUNICABLE DISEASE.

One from the standpoint of the lawyer by Judge A. J. Mills; from the standpoint of the clergyman, by Rev. F. Z. Rossiter, of Kalamazoo; and from the standpoint of the health officer, by Dr. Foster Pratt, of Kalamazoo. Judge Mills specified the several classes of laws

relating to public health, which it is the duty of the citizens to uphold, by co-operating with the health authorities. Rev. F. Z. Rossiter dwelt upon the peculiar traits of each of the dangerous communicable diseases. He took a model city which he called Fair View, and outlined the objectionable conditions as well as desirable conditions in such a place.

Rev. R. E. Jones, of Kalamazoo, said if the public would not uphold the officers, the law could not be enforced. It is the duty of the citizens to uphold the officers, and of the officers to enforce the laws which they have sworn to enforce.

Dr. Foster Pratt, of Kalamazoo, asked attention to the fact that scarlet fever and diphtheria are dangerous and fatal diseases, causing deaths compared with which the deaths from small-pox are insignificant; yet that people do not fear them shows that they do not understand the facts. Citizens should inform themselves on these subjects, and then they should coöperate with the officers of local, state and national boards of health for the exclusion, prevention and retrictions of communicable diseases.

The President of the Convention, Judge Severens, before the close of the session, said that the purpose of the convention had been noble. The statutes of the state in an early day on sanitary subjects were of no account, but of late a scheme had been developed which showed some good sound sense. These conventions are for the benefit of the people. The attendance had been light, but the publication of the paper would instruct and benefit many others. Great good, he thought, would be accomplished by the continuation of conventions of this kind.

### Correspondence.

#### HAY FEVER IN KENT CO., MD.

CHESTERTOWN, MD., June 14, 1886.

*Editor Maryland Medical Journal.*

DEAR SIR.—In the very interesting article of Dr. Joseph Blum, read before

the Clinical Society of Maryland, on Hyperæsthetic Rhinitis, and published in your issue of June 12th, the statement is made by Dr. Blum, on the authority of Mr. A. P. Sharp, that "Hay Fever is unknown to the physicians of Kent Co., Maryland, and that very few cases of neurotic asthma or phthisis have been encountered."

I wish, as a practicing physician of Kent County, I could give my testimony as to the correctness of this statement, but unfortunately I have among my patients two undoubted genuine cases of hay fever, besides others of neurotic asthma and phthisis. I also happen to know of other cases of hay fever, under the care of a medical friend. Both of my cases of hay fever occur in August and last generally from fourteen to eighteen days, during which time it is hard to determine who suffers the most, the stricken ones or the doctor who has to bear the burden of the fight for relief. If there is among your readers some one who has been more successful than the ordinary run of practitioners in treating such cases, please let us hear from him.

Respectfully,

W. FRANK HINES, M. D.

OPHTHALMIC OPERATION AND TETANUS.—Dr. D. Juan Santos Fernandos, of Havana, gives in the *Crónica Médico-Quirúrgica* an account of a fatal case tetanus following the extirpation of the eyeball for atrophy following the removal of a sarcomatous tumor from the orbit. In commenting upon it, he remarks that the only four other cases of tetanus following ophthalmic operations which he has been able to find in medical literature all proved fatal, which tends to show that though tetanus rarely follows such operations, it is particularly dangerous when it does supervene. In none of the cases was the operation intra-ocular merely, such as cataract extraction or iridectomy, a class of operations which Dr. Fernandos believes never to have been followed by tetanus.—*Lancet*, June 5th, 1886.



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BALTIMORE, JUNE 26, 1886.

Editorial.

THE RADICAL TREATMENT OF VARICOCELE AND HYDROCELE.—The two above affections are among the most frequent conditions which come under the treatment of the surgeon, and it would be difficult to mention anything about which opinions vary so much in regard to their proper management. Varicocele is present in a large number of persons and its presence can be said to give rise to little more than slight inconvenience. But in a certain number of cases either from the size and weight of the tumor, or the nervous symptoms with which it is accompanied measures for relief are very desirable, and these have heretofore been generally confined to ligature of the veins with silk or wire, or ablation of a portion of the scrotum. The former plan is the only one which gives any promise of permanent cure since the latter does not concern itself with the varicose veins, but rather aims to transform the scrotum into a permanent close-fitting suspensory bandage. These operations have not proved satisfactorily in the main, and conservative surgeons are prone in the majority of cases to advise the patient to content himself with the relief afforded by suspensorium. This want of success on account of pain, suppuration, danger of septicæmia and unsatisfactory results has led Dr. Keyes (*N. Y. Medical Record*, February 20th, 1886) to devise the operation of subcutaneous ligature with carbolised cat gut. The method of applying the

gut is simple; the patient standing, a staff needle armed with a loop of silk and the end of the catgut is passed from before backwards between the viens it is proposed ligate and the rest of the cord. The catgut being now hooked out of the eye of the needle the latter is withdrawn through the last made puncture and the veins being allowed to join the rest of the cord, the needle is manipulated around outside them and made to emerge from the same opening. The catgut is now threaded through the loop of silk and the needle withdrawn thus leaving the catgut ligature around the veins. The gut is tied with a triple knot, cut short and drawn within the first puncture, the punctures closed with bits of plaster and the operation is complete. Dr. Keyes has operated by this method on a large number of cases and with results which encourage him to call the attention of the profession to it. The operation is done under complete antiseptic precautions and as the result, there has been no untoward complication in any of the cases. In discussing the matter of hydrocele Dr. Keyes calls attention to the method of radical cure for which the profession is indebted to Dr. Levis, of Philadelphia. Dr. Levis draws off the fluid and injects through the canula by means of a neatly fitting syringe a drachm of deliquesced carbolie acid. Dr. Keyes modifies the method somewhat. He uses a glass syringe, holding a hundred minims, with a hypodermic point, and with this withdraws the fluid from the sac and also injects the acid thus avoiding the contact of the acid with the surgeon's fingers or the surface of the scrotum. If the sac is very large the hypodermic point is first introduced and its position verified by the escape of a drop of fluid. Then a fine aspirator needle is passed into the sac and the contents withdrawn, after which the acid is injected. The use of deliquesced carbolie acid in this way has already made favorable progress among surgeons and Dr. Keyes' testimony in favor of its painlessness, freedom from danger and certainty of cure will no doubt make it still more popular.

**THE DIURETIC INFLUENCE OF COCAINE.**  
—Since attention was first called to the local anæsthetic properties of cocaine the use of this drug has assumed the widest application.

As an anæsthetic cocaine has been employed for almost every condition in which anæsthesia was indicated. The usefulness of the drug seemed almost inexhaustable in rendering mucous surfaces insensitive to pain, but the limit was not yet reached. It was ascertained that by injection into the deeper tissues capital operations were easily performed without pain, amputations, removal of necrosed bone and even laparotomy having been successfully performed, cocaine being the anæsthetic agent employed. To the surgeon cocaine has proven an invaluable agent, but its uses in medicine were not deemed of equal service. Recent experiments go to show that even the physician can find a field for the employment of this drug. In some researches made at the Pennsylvania Hospital by Drs. J. M. DaCosta, and C. B. Penrose (*Medical News*, June 19th, 1886) it was noticed that cocaine administered hypodermically, and by the mouth, increased the flow of urine. It was observed in the Hospital that where there were patients taking cocaine for one purpose or another, with a single exception the flow of urine was greater and in some instances became a matter of inconvenience to the patient by obliging him to get up at night.

In order to test the diuretic action of cocaine in an accurate manner, Drs. DaCosta and Penrose selected eleven cases for study, in which the urinary secretion had been watched for sometime and found to vary but little, and to which during the administration of cocaine, as well as for a day or two before, no other remedy was given. The results of eight cases are now given. They represented persons wholly free from any organic disease; or—though in one instance only—with a cardiac lesion; or with Bright's disease of the kidneys; a varying list purposely selected. In three of the eleven cases the quantity of urine was somewhat increased by one grain of cocaine three times daily, but

not sufficient to give a decided result. Of the other eight cases three had Bright's disease of the kidney, in one of the form of chronic parenchymatous nephritis attended with considerable dropsy, not due entirely to the renal lesion, for there existed a mitral and aortic disease, with a heart of only moderate strength. The increase of urine in this case was very striking and rapid; the dropsical symptoms were much relieved. This patient took one grain thrice daily, hypodermically. The quantity of urine passed measured eighty ounces on the first, second and third days and ninety-six ounces on the fourth. In the second case albumen was present in small quantity; the diuretic action of cocaine was most striking. Before giving cocaine the daily amount of urine measured fourteen ounces, and the second day after taking one grain by the mouth it measured eighty-eight ounces. On the third day after taking one-half of a grain it measured seventy-two ounces. The drug being withdrawn, on the sixth day the quantity of urine dropped to twenty-four ounces.

The practical question whether the amount of albumen is diminished by cocaine is answered in the negative by the experimenters. They observed that the relative amount of albumen in a given quantity of urine was apparently unchanged and therefore conclude that in chronic cases of the disease the use of cocaine is contra-indicated, except for temporary purposes.

The question as to what elements of urine are excreted in larger amounts under the diuretic action of cocaine is answered by the statement that the solids are excreted in larger amounts.

Cocaine raises arterial tension and this is offered as an explanation of its diuretic action, and also accounts for its occasional failure as a diuretic by too great a tension.

It was observed that the diuretic action of cocaine is persistent, the urinary flow remaining free for sometime and for a certain period was more easily influenced by other diuretics than before. The therapeutical application of these observations are thus stated by Drs. DaCosta



and Penrose. "Irrespective of its diuretic influence we ought to obtain advantage from cocaine in instances of weak heart with dropsy; and, so far as we have been able to pursue this line of investigation, such is actually the case. In uræmia, with scanty secretion of urine, the remedy is also well worth a trail."

#### REPORT OF ALBUMEN TEST COMMITTEE.

—The Albumen Test Committee recently presented its report to the Clinical Society of London, (*Lancet* June 5, 1886). The committee briefly reviewed the various modes of urinary testing for albumen in common use, and compared in turn Dr. Oliver's test-papers, Dr. Johnson's picric acid method, the potasio-mercuric iodide and acid, Dr. Pavy's pellets, the acid brine method, picric acid and brine, the acetic acid, and the nitric acid methods. The portability and delicacy of reaction of Dr. Oliver's papers were considered strong recommendations in their favor, but apart from the question of easy carriage and compactness, the committee decided that nitric acid was most reliable and delicate. All the other methods were, however, considered respectively useful in determining various proteids that might be in urine.

#### Miscellany.

A DOCTOR'S EXPERIENCES IN THREE CONTINENTS.—Such is the title of a most interesting and charmingly egotistic book of some six hundred pages by Dr. Edward Warren-Bey. It is in a series of letters to Dr. John Morris, of Baltimore, and being in the form of letters to an intimate friend the frequent use of the first personal pronoun, so far from being at all disagreeable, adds to the interest of the volume. The letters are not in the form of a diary, but facts, dates and comments are given in a manner which is at the same time connected and disconnected. The personal memoirs of distinguished men are always of interest, particularly when well written, and it is apparent from these letters that Dr. Warren's fluency of speech is not

greater than his readiness with his pen.

A man who took an active part in the surgery of the late war, who has been an active practitioner in two sections of this country, chief surgeon of the Egyptian War Department, and for some years an active practitioner in Paris, the friend of the much lamented Otis and Gross, of Charcot, Zeb Vance, Ismail Pasha, Landolt, Abbate-Bey, General Mott, Alfred Swaine Taylor, Thomas Stevenson, and Sir James Paget, could but have an interesting history. Very much of this written history is a record of trials and sorrows, some of which must come to everyone, and of difficulties overcome. Perhaps one of the most remarkable facts in the life of Dr. Warren is that he did not study the profession of his first choice—law—but was induced by his father to study medicine. This is chiefly remarkable on account of his eminently successful career as a physician.

Taken altogether, we do not know of any book, the reading of which will make an evening pass more quickly or more pleasantly, and the chief regret on parting with it is that it is not longer. For those who are inclined to believe that there is nothing good in America, who buy their watches in Geneva, their umbrellas in Paris, and their ill-fitting clothes in London, we particularly recommend the following, from the last letter:—"Before bidding you adieu, I must say this much: The longer I have resided abroad, the more intensely American have I become, and the greater has grown my love and appreciation of my native land. Other lands may possess their treasures of art, their marvels of luxury, their triumphs of architecture and all that is calculated to captivate the imagination and ravish the senses, but for the truest solution of the problem of human existence, the grandest victories of human skill over the laws of nature, the most fortuitous combination of those conditions which constitute society, and the perfection of a governmental system—that which governs the least and protects the most—America is the land preëminently blessed of Heaven. Call me an enthusiast if you

will, but for me her skies are the brightest, her mountains the grandest, her rivers the broadest, her fields the greenest, her women the loveliest, her men the noblest, her history the proudest, and all that relates to her the best of all the world besides. Elsewhere her sons may be content to linger for a season, but to them she is the only land in which they can ever realize the idea of *home*, or feel that they are aught else than aliens and sojourners."—*Journal of American Medical Association*, May 22, 1886.

**NITRO-GLYCERINE IN THE TREATMENT OF CHRONIC NEPHRITIS.**—Dr. Francis Kinnicutt has conducted a series of clinical investigations, with a view of determining the value of nitro-glycerine as a remedy in certain kidney affections. From these studies, he feels justified in drawing the following conclusions:

1. That in nitro-glycerine, given in small doses and frequently repeated, we possess a powerful agent for lowering the increased blood-pressure, which is very constantly associated with the development of uræmic symptoms.

2. That it has the power to control or relieve many of the paroxysmal disturbances of the nervous system, which are included under the general term of uræmia; of these headache and asthma are especially benefited by its use, the relief being more marked and continuous than that obtainable either by opium or chloral.

3. That its influence on the daily excretion of urine and serum albumen in parenchymatous and interstitial nephritis is apparently to decrease the former and diminish the later.

4. That in the systematic and prolonged use of nitro-glycerine, in appropriate doses, in chronic nephritis we possess a means of maintaining, more or less continuously, a lowered blood-pressure, of often averting or relieving critical conditions and thereby prolonging life.—*Med. Record*.

**SUCCESSFUL EXTIRPATION OF THE SPLEEN.**—*Lancet* (June 5, 1886), reports from *La Gazzetta degli Ospitali*, (May

23,) a case from the surgical clinic of the University of Genoa in which Professor A. Ceci removed a greatly enlarged spleen from a girl aged 17 years. Thirty-one days after the operation the patient was reported in excellent condition and a more recent note from Professor Ceci states that the patient is in good health; pulse 80; respiration 22; weight increasing rapidly; complexion florid. The extirpated spleen, with the contained blood, weighed 77.16 ounces.

**CHOLERA IN SOUTHERN EUROPE.**—With the advent of the summer months the increase of cholera in Southern Europe is a matter of great certainty. Reports already announce an increasing prevalence of the disease along the Austrian frontier on the south and in Italy. It is certain that the Italian Government have been maintaining a strict silence in respect to the existence of cholera in order to avoid the imposition of measures of quarantine upon their vessels by foreign countries. That the disease is widely prevalent in Italy there seems little doubt.

**SUDDEN DEATHS AFTER SEVERE EXERCITION.**—Two deaths have recently occurred which ought to serve as a note of warning to those who undertake severe muscular exertion without due preparation for the same. In one case the fatal results occurred during an Alpine excursion; in the other after a sharp row on the river; in both death was by syncope. It is probable that in each case, had the work been undertaken gradually and with some degree of training, instead of a fatal result ensuing, the bodily health might have been improved. Both of the deceased persons were of an age when degenerative changes in the muscular tissue of the heart or of the vessels would hardly be expected, and the syncope must have resulted from the sudden strain thrown on the cavities of a heart weakened previously by a long period of inactivity, and before the concordant action between the heart and great vessels had been established. This is always a danger when violent exercise is suddenly undertaken, and the mischief



is of course greater in elderly persons than in young adults. Many middle-aged men who, at the commencement of their autumn holidays, after months of comparative inactivity, undertake without preparation some feat of Alpine climbing, or a long day's grouse shooting on the moors, lay the foundation of future heart troubles or aneurism simply because they will not allow time for the concordant action between the heart and great blood vessels to be established. In all cases where men are suddenly called upon to exchange a sedentary life for one of increased activity, they should consult their medical attendant as to the condition of their circulatory system. One instance is particularly recalled to us of a distinguished general practitioner, who had long been troubled with a spasmodic cough, which he thought proceeded from deranged stomach, and which a month among the Alps would soon put right. He started on his journey, but fortunately *en route* he travelled in the same carriage with a physician who was personally a stranger. During the journey the physician was struck with the character of the cough, and after a little conversation an examination of the chest was made, which resulted in the discovery of an aneurism of the transverse aorta, which had escaped the patient's notice. Had he made any of his contemplated ascents he would have aggravated the condition, even if the attempt had not led to sudden rupture of the sac and immediate death. —*Lancet*, June 5th.

**THE DANGERS OF KISSING.**—Dr. R. Stansbury Sutton says in the *Journal of American Medical Association*, "About 1872 a young man presented himself at my office with a full-blown chancre on his penis, and syphilitic sore mouth. He was treated *secundam artem* and went his way. Some weeks later I received a letter from him saying that his chancre was healed and that he was doing well, but that he was in further trouble—that a few days after consulting me he had kissed a young lady at an evening party in Altoona and that she had syphilitic sore mouth as a result.

Recently I was consulted by a young married woman. She was a stout, robust person, of great natural physical strength. She presented a squamous eruption, syphilitic sore mouth and condylomata. I sent for her husband. He was perfectly healthy; vowed and I believe truthfully, that he was and had been pure. I told him the condition of his wife, and warned him against infection. We then began an investigation of the origin of the wife's infection. And it may be well stated here that I had not questioned her chastity. I knew the woman. The search was attended by success. A brother had long been absent, returned home with syphilis, kissed his sister and infected her. He remained at home for some time, and during the time was treated for his malady by a physician within three minutes' walk of my office."

**MEDICINE AND ART.**—The London Correspondent of the *N. Y. Medical Record* writes: "No medical artist has an exhibit at this year's Royal Academy exhibition, though there is a notable collection of medical portraits, busts, and statues by professional artists. Sir Henry Thompson has no work in the "Academy," though he exhibits a beautiful Italian landscape at the Grosvenor Gallery. Yet many of our profession possess no mean skill with the brush, pencil, or burin. As etchers, Mr. Seymour Haden and Dr. Evershed have attained considerable repute. The former is a surgeon (now retired), who some few years ago created some stir by his denunciation of the current insanitary methods of burial in solid wooden or leaden coffins. Numerous vigorous letters from his pen appeared in the *Times*, giving graphic descriptions of some graveyard explorations, and advocating the employment of perishable coffins. Dr. Evershed is a practising physician and is attached to one of the consumption hospitals. Many other names might be mentioned. Of art connoisseurs our profession has had, and still has, many within its ranks. Among these the late Dr. Billing was noteworthy for the valuable collection of gems and cameos he possessed. Turning

to the sister art, the drama, more than one medical man has appeared on the stage. One distinguished ophthalmic surgeon in London, now enjoying a large and lucrative practice, had formerly, I believe, some idea of devoting himself entirely to the dramatic art."

**INCIPIENT BALDNESS.**—In commencing alopecia, Vigier advises the use of the following formula, in which the proportions are given by weight:

Alcohol (80°)	. . .	3 xx.
Camphorated alcohol,		
Rum,		
Tincture of cantharides,		
Glycerine	. . .	āā Div.
Essence of sautal, wintergreen,		
laurel roses	. . .	āā gtt. v.
Muriate of pilocarpine	. . .	gr. viij.

The mixture is gently rubbed on the scalp once daily.—*Revue de Thérapeutique*, May 15, 1886.—*Med. Times*.

### Medical Items.

The *Medical News* states that were 600 deaths from typhoid fever in Philadelphia last year.

It is proposed to locate the Medical Department of the West Virginia State University at Wheeling.

Dr. Domingo Freire, of Rio Janeiro, claims to have performed over seven thousand inoculations for yellow fever by his method, with full success.

The Queen has conferred the honor of knighthood on Mr. John Tomes in recognition of his eminent services to the profession of dentistry.

The Philadelphia County Medical Society at its regular monthly meeting held June 2nd, refused to admit female physicians to membership.

Dr. G. G. Kinloch, a promising young physician, of Charleston, S. C., died on June 7th, from the effects of injuries received in a railroad accident. He was a son of Dr. R. A. Kinloch.

Dr. W. T. Howard, of this city, took passage for Europe on the steamship Eurania, on June 19th. Professor Howard will spend some three months in foreign travel. His many friends here wish him a safe and happy tour, and a restoration to robust health.

Dr. H. P. C. Wilson, of this city, entertained the members of the Baltimore Gynecological and Obstetrical Society at his handsome country seat "Idlehigh," in Baltimore County, on Thursday the 24th. The occasion was greatly enjoyed.

The Home for Incurables, of this city, has recently received a legacy of \$5000, from a deceased friend of the Institution. The Home was incorporated less than three years ago and now owns between \$35,000 and \$40,000, all of which has been raised by donations, subscriptions and entertainments.

The honor of Knight Bachelor has been conferred by the Queen upon the following gentlemen: Surgeon-General T. Longmore, Professor of Military Surgery, Netley Hospital, Dr. E. H. Sieveking, Mr. W. White Cooper and Dr. Douglas MacLagan, Professor of Medical Jurisprudence in the University of Edinburgh.

Dr. Gudden, who lost his life in an effort to rescue King Ludwig, of Bavaria, from drowning, was a man well known to students of medicine by reason of his contributions to science. He originated a new method of research known as the "atrophy method," which has been of great service in elucidating the difficult problems of brain anatomy.

The *N. Y. Medical Journal* states that an infirmary is to be established, in New York City, for the gratuitous treatment of persons suffering from venereal diseases, either acquired or transmitted. The board of directors is said to be composed of Dr. T. Gaillard Thomas, Dr. A. L. Loomis, Coroner Levy, and other well-known gentlemen.

The statue of John Hunter, "the father of scientific surgery," was unveiled in the new museum at Oxford, by Her Royal Highness Princess Christian, on the 29th of May. Addresses appropriate to the occasion were delivered by Sir James Paget and Sir Henry Ackland. The statute represents the great *savant* standing with legs crossed, and supporting himself on a pillar or post, with a remarkably keen and searching countenance. It is one of five statues, representing heroes of science, presented to the University by Queen Victoria.

Sir Henry Thompson is among the noble army of the medical novelists, or, as we might almost say, has gone over to the majority. The neurologist novelists have a fund of experience in their specialty which is often available for the purposes of fiction. But what Sir Henry finds in his specialty to adapt for such ends, is a matter of curious conjecture. The title of his latest work is announced as "All But." Theories are rife among those who have as yet failed to obtain the book, as to whether the plot turns on a case of defeated catheterization, or of the persistence of residual fragments after a lithotripsy.—*Boston Med. and Sur. Jour.*



Original Articles.

A CASE SIMULATING A MEDIASTINAL TUMOR WITH SPECIAL LARYNGEAL SYMPTOMS.\*

BY EDWARD T. BRUEN, M.D.,

Physician to the Philadelphia Hospital and Assistant Professor of Physical Diagnosis, University of Pennsylvania.

There are certain lessons which can be drawn from the post-mortem examination of any case in which, during life, the diagnosis was subject to debate. I, therefore, desire to invite attention to a few considerations based upon certain specimens which I shall exhibit. The first represents a tumor originating in the œsophagus near its junction with the pharynx. The patient, A. C., was a well-nourished man, sixty-four years of age, six feet high, and weighing 186 pounds just before death.

He had been a shoemaker by trade and had been accustomed to labor with his shoemaker's last pressed against the sternum. His history was free from taint of rheumatism, syphilis, or Bright's disease. He entered the hospital in May, giving the history that in the preceding month he had commenced to suffer from paroxysmal dyspnœa which occurred without warning or assignable cause. He had few subjective symptoms, and no pain; cough had been somewhat troublesome for a month before admission, with expectoration which was mucous, white, and frothy. Toward the close of his case, for he died August 20th, swallowing became difficult, although he was able to take liquid food to the last, and, therefore, did not lose flesh rapidly and presented the appearance of health.

The physical signs were in a measure those which usually accompany a mediastinal tumor, but disturbances of the respiration were most conspicuous. Whittier places the disorders of respiration in intra-thoracic disease in the order of their value in diagnosis as follows: rapid breathing, dyspnœa on exertion, dyspnœa on change of position, dyspnœa

explained by physical signs, orthopnœa, paroxysmal dyspnœa. In our patient there were paroxysmal attacks of dyspnœa which were somewhat increased on exertion but not on change posture. These attacks could not be explained by the physical signs indicating pressure upon the branches of the bronchial tree, and the effects of pressure such as areas of collapse of pulmonary lobules, or areas of pulmonary consolidation, could not be detected. In a word, the dyspnœa seemed to be distinctly connected with pneumogastric irritation.\*

Toward the close of his life, for he died August 20, 1885, the dyspnœa was more constant, and dysphagia became a pronounced symptom. His death occurred suddenly and was apparently due to obstruction of the larynx, probably spasm of the glottis. The autopsy revealed a tumor of the right lateral aspect of the œsophagus at its junction with the pharynx. The growth had increased backward and to the right, forming an enlargement which extended toward the vertebræ and also forward along the side of the thyroid cartilage. The right wing of the thyroid had been destroyed, but the larynx had not been penetrated. The new growth measured in vertical diameter two and one-fourth inches, and transversely about the same, although quite a pocket had been formed in the tissues beside the thyroid cartilage. Owing to this forward projection of the above named pocket the epiglottic cartilage was tilted backward; the cartilage itself was very large measuring one and three-fourth inches from base to tip. The œsophageal mucous membrane was softened and ulcerated. The growth was found, on microscopic examination, to be an epithelioma of the squamous variety. The thyroid body was enlarged but there were no other important changes in any of the organs of the body.

The upper portion of the sternum was removed and examined, and it was found to be an unusually thick bone especially for about two inches below the notch.

\*Read before the College of Physicians of Philadelphia, June 2, 1886.

\*Dyspnœa as a Symptom of Intrathoracic Pressure, *Philadelphia Medical Times*, October, 1879. Bruen.

Behind this part of the bone lay a large accumulation of adipose material, in fact, almost entitling one to call it a lipoma. The mass was three inches long by two inches across.

The case is fruitful in suggestions, especially as during life it was considered to be a case of intra-thoracic tumor originally situated in the anterior mediastinum, and extending backward. In the latter stages of the disease this view of its anterior location was somewhat shaken by the increasing prominence of symptoms of pressure upon the œsophagus. The evidence which was regarded as indicating the origin of the growth in the anterior space, was that such pressure symptoms as were present seemed to be only exercised in parts in the mesial line, and recognizing that growths in this region may attain a large size and grow with great rapidity, the increase of pressure symptoms upon the œsophagus did not attract as much attention as in a hypothetical case they might assume.

In the accompanying specimen we have an illustration of a tumor occupying the anterior mediastinum and exercising pressure upon parts in the mesial line, including the œsophagus. In the autopsy made by the writer,\* on removing the sternum and cartilages they were found to be adherent on the right side to a mass which occupied the anterior mediastinum. The growth was seven inches long, measuring from the sternal notch, and terminated in a somewhat diffused thickening of the visceral pleura, which covered the anterior margin of the upper and middle lobe of the right lung. The growth was two and one-half inches broad. It overlaid the aorta, pulmonary artery, and the vessels of the neck. The calibre of the trachea was slightly diminished. The glands of the neck were unaffected on either side. The posterior mediastinal glands were very slightly enlarged along the sides of the trachea and upper bronchi. Laterally, at the lower portion of the growth, the pulmonary pleura was thickened at the line of contact of the tumor, but the lungs were

free from any traces of disease. The new formation was of fibrous consistence, of a gray-white color, and through its centre a softened tissue was found. Microscopic examination showed the growth to be composed of median-sized lymphoid cells mixed with spindle-shaped cells, and embedded in a homogeneous stroma, or a stroma which consisted of reticulated fibres and wavy fibrous tissue. Other portions of the body were normal.

In some cases of tumor in the anterior mediastinum pneumogastric irritation is conspicuous. In a case reported by West in a similar situation the left phrenic and left pneumogastric nerves passed through the mass, and on dissection were found much thickened as they ran through the tumor. The tenth nerve measured three times its normal diameter and was pushed out of its course nearly an inch from the carotid. The recurrent laryngeal nerve was also thickened; the right pneumogastric and phrenic nerves were not involved.

Dysphagia is usually not observed in cases of growths in the anterior mediastinum, or is slight in proportion to other signs of pressure, but it may be simply a symptom of irritation, of the intra-thoracic nerves or due to enlargement of the glands in the posterior mediastinum.

In the case of A. C., there was marked dulness over the upper piece of the sternum, and the heart-sounds were remarkably distant and muffled. These symptoms were explained by the finding, on post-mortem, of a thick and arched sternal bone with a cushion of fat behind it.

The condition of the general health in advanced cases of intra-thoracic tumor might offer some basis for differential reasoning upon the nature of a mediastinal tumor previously recognized by other physical signs. For instance, it is regarded as significant of aneurism if the general health is fair with marked pressure symptoms. But it is well established that sarcomatous growths may coincide with an appearance of fair health, and this adds perplexity to the differential diagnosis between aneurism and morbid growth. The case of A. C.

\*See System of Practical Medicine, Pepper: Diseases of the Mediastinum, p. 866.



can be appealed to as an illustration of an epithelial cancer which caused partial obstruction of the œsophagus, and yet the subject was fairly nourished to the end. There were no evidences of pulmonary invasion, the respiration was whistling or stridulous when the stethoscope was placed over the trachea, but there was fair respiratory murmur over each apex; nor was there any evidence of pressure on the roots of the bronchi such as is sometimes seen in cases of growths in the anterior mediastinum when the growth increases in size. This fact should probably have been given more weight in the differential diagnosis, but the physical signs of intra-thoracic disease seemed so decided that the symptoms of laryngeal dyspnœa were incorrectly interpreted.

These larygeal phenomena formed the most important features of the case. During life the overhanging epiglottis prevented a satisfactory view of the vocal cords, but when a glimpse was possible the right arytenoid was almost motionless and the vocal cord tensely stretched and in the phonative position in the median line. The voice was uniformly high-pitched, and when an attempt was made to give a higher note, was shrill. There was a good deal of venous congestion, but no glimpse of the growth could be made out; indeed, a prolonged laryngoscopic inspection could not be made, since the introduction of the mirror tended to bring on dyspnœa and laryngeal spasm. The dyspnœa and laryngeal spasm during life arose through implication of the pneumogastric nerve, for the right laryngeal must have passed through the growth.

The condition of the vocal cords in intra-thoracic disease is always worthy of special observation. I have notes of two cases in which I noticed permanent or tonic spasm of the vocal cords.

C. Burke, æt. 49. During life immobility of the left vocal cord was observed. The left arytenoid was almost motionless, and the cord was permanently fixed in the median line whether phonation was attempted or not. At times the left arytenoid was drawn slightly toward its fellow of the opposite

side. The right vocal cord was normal in its action. Inspection showed some venous congestion of the laryngeal tissues. The voice, while ordinarily not loud, was abnormally high pitched, and when attempts were made to give a very high pitched tone, was shrill. The post-mortem confirmed the diagnosis established during life, viz., atheroma and dilation of the aorta and also of the pulmonary artery. The specimens from this case I present at this time, but will refrain from entering into a detailed discussion.

Martin S., æt. 50, a patient now living in the Philadelphia Hospital, is believed to have an aneurism of the ascending aortic arch near the transverse portion. Laryngoscopic examination is difficult on account of irritability of the throat. He complains of marked dyspnœa and possesses a high-pitched voice, which becomes louder, more shrill and stridulous on making a high note. The epiglottis is large; pale and pendant. Arytenoid of right side fixed in phonative position with cord—of course, in median line as in the former case, while the left arytenoid and cord are normal in action. The mucous membrane appears thickened and shows venous congestion.

The explanation of this condition of the cords is still unsettled, being variously assigned to irritation of the nerve fibres, or by others to paralysis of the abductors, which are said to lie on the peripheral aspect of the nerve.

In connection with this condition of the vocal cords, it may be well to recall the original observations of Semon\* "on the proclivity of the abductor fibres of the recurrent laryngeal nerve to become affected sooner than the adductor fibres, or even exclusively in cases of undoubted central or peripheral injury or disease of the roots or trunks of the pneumogastric, spinal accessory, or recurrent nerves." According to the observation, the vocal bands should remain fixed in the phonative position and recede to the cadaveric position only when the adductor filaments become paralyzed.

\*Arch. Laryn., July, 1881, p. 197. *International Ency., Ashhurst*, vol. 5.

He continues, this initiatory phase of the paralysis being usually unilateral does not markedly affect the voice and hence escapes recognition, laryngoscopic examination being rarely instituted until impairment of voice has resulted from complete paralysis, with the cord fixed in the cadaveric position.

In the *Polyclinic* for January, 1886, a case of similar character to those just related is reported from the practice of Dr. J. S. Cohen, by Dr. A. W. Watson. The intra-thoracic lesion in this case was aneurism of the aorta and left subclavian artery. The left vocal cord is described as fixed in the median line in the phonative position. The voice was stridulous and high-pitched. It would appear, therefore, that the position of the vocal cords should afford most valuable auxiliary data in the early diagnosis of intra-thoracic disease, and possibly from the relations of the recurrent laryngeal to the aorta and subclavian arteries the symptoms might be looked upon as ranging itself particularly among those indicative of aneurism. But at the same time, to illustrate the multifarious meaning of any symptom connected with mediastinal disease, we must note the occurrence of this symptom in connection with cancer of the upper portion of the œsophagus, and the misinterpretation of the laryngeal phenomena.

In review, we may say that the case presented illustrates anew the complexity of the diagnosis of mediastinal disease. The liability to error in deciding the location of the process is well explained by the post-mortem specimens. Indeed, the tumor was really situated in the neck, but as the patient had a short neck, very thick and fat, no swelling could be distinguished. The thick sternum with its underlying cushion of fat was misleading. Lastly, the mode of death was unusual, since in disease of the œsophagus the termination is generally brought about by inanition, marasmus, hæmorrhage, or perforation into adjoining organs. It has also seemed possible that since the right wing of the thyroid cartilage was perforated, the laryngeal lumen must have been sensibly diminished and lodgment of food in the

pocket formed in the œsophagus might have produced occlusion and brought on reflex spasm, or the lumen of the glottis already narrowed may have been occluded by the sucking into it of the folds of loose tissue. During the clinical study of the case some etiological importance was assigned to the question of avocation on the basis that sarcomata may claim a connection with direct irritation; but this, of course, was of minor importance especially as the only reason for forecasting that the supposed mediastinal tumor was a sarcoma, was based on the observation that tumors of the anterior mediastinum are usually of this variety.

#### DISCUSSION.

*Dr. James C. Wilson:* Dr. Bruen has spoken of my having seen the case. I can only say that I quite agree with Dr. Bruen and my colleagues in the hospital as to the obscurity of the diagnosis. One of the questions brought up at the consultation was with reference to the possibility of the symptoms being due to substernal abscess, abscess of the anterior mediastinum. This view of the case, I think, most of my colleagues were unable to accept, although some of the phenomena pointed strongly to it. This point was raised with the view of determining whether or not any surgical procedure should be instituted. After several careful examinations the diagnosis of abscess was considered inadmissible.

With reference to sudden death in cases of malignant disease of the œsophagus, I may state that within a brief period after this case was under observation, I had a case in the hospital where sudden death occurred in a negro woman aged sixty. At the post-mortem there was found quite a small malignant growth of the œsophagus, occupying about the same position as the tumor in Dr. Bruen's case. In my case there were no physical signs and only two symptoms, namely, occasional slight difficulty in swallowing solids and paroxysmal dyspnœa.

*Dr. Bruen:* The question of abscess was specially developed by Dr. Agnew. There was a certain amount of œdema,



redness, and tenderness above the sternum. The introduction of a drill through the sternum as a diagnostic measure was discussed, but was finally decided that it would not be prudent to do so. During the last week the symptoms of pressure on the œsophagus increased very rapidly. This, I think, was due to the accumulation of food or broken-down material in the pocket which I have demonstrated, and thus narrowing the œsophageal lumen.

*Dr. James H. Hutchinson:* Dr. Longstreth has reminded me of a case of cancer of the œsophagus in my ward of the Pennsylvania Hospital. There was complete occlusion of the œsophagus and the patient had been unable to swallow for several days. I had given the patient up, but at the suggestion of my resident, Dr. T. S. K. Morton, I administered half a grain of cocaine. This enabled a quart of milk to be taken within half an hour. Subsequently the administration of one-twelfth of a grain enabled him to take a pint of milk. In this way his life was prolonged at least ten days.

## PASTEUR AND HYDROPHOBIA.

BY AUGUSTUS E. GOSWEILER, M.D., OF  
BALTIMORE.

So much depends upon a settlement of the question whether Prof. Pasteur really has or has not, out of all the incalculable possibilities of error, succeeded in choosing the one and only truth in relation to certain pathological conditions, that the length and earnestness of the debate that is going on may well be pardoned. For nearly a quarter of a century he has been assailed, and each new development in the wonderful series of investigations, that began in the beer vat and is even now proceeding to demonstration in the brain and nerve of man, has intensified the bitterness of his opponents. At the same time it has given stimulus and direction to the thought of mankind which is beginning to observe that every success that he has met with in successful hypothetization of the germ serves to build more broadly

and firmly a reasonable and striking pathological law which may yet in our own time make medicine as exact a science, speaking within limits, as surgery, or even chemistry.

M. Pasteur's efforts are at present directed towards solving the problem as to how the virus is attenuated in dry air.

Through such experimenting on the subject he is disposed to lean towards the opinion that the virus of rabies behaves with some analogy to that of chicken-cholera, which, on long cultivation, seems to produce a substance which proves poisonous to its own self, checking its growth and generally destroying its vitality. Indeed, thanks to M. Pasteur, surgery and medicine have not only been brought into fraternal relations, but share the mysterious unity of twinship. The germ is the tie that binds the knife to the therapeutical remedy.

The latest and most impressive work done by M. Pasteur is, as is well-known, in relation to the subject of rabies in animals, principally in dogs, and the prevention of hydrophobia in human beings. It is probably in this relation that he is best known to the laity, although his eradication of chicken-cholera, splenic fever in cattle and disease among silk worms has saved to France a sum of money probably many times greater than Bismarck exacted from France as a war indemnity.

We find the etiology of hydrophobia, in connection with M. Pasteur, treated of with great skill and ability in a paper by Dr. Hermann M. Biggs, and published in the *N. Y. Medical Journal* for April 24th last. The writer sets forth with admirable clearness and mastery of the subject the essential character of the Pasteur treatment, and concludes with a two-fold summary of the evidence in favor of accepting it as a demonstration. One of the arguments he quotes from Professor Tyndall, himself a tower of scientific strength and judgment. The great English authority to his introduction to his life of Pasteur, recently published by the Macmillans, presented as an almost final proof of the correctness of the treatment a table of canine acknowledgment which may be summarized thus:

Of six dogs, unprotected by vaccination, three died of rabies after being bitten by a furiously rabid dog.

Of eight unvaccinated, six died after intravenous inoculation of rabic matter.

Of five unvaccinated dogs all died after trepanning and brain surface inoculation.

Of twenty-five vaccinated dogs not one was attacked with disease after inoculation with the most potent virus.

The other line of argument advanced by Dr. Biggs is that of probability. He asks whether a man who has in brief performed such well attested wonders as Pasteur would be likely, after five years of ripe experience and patient trial, to be deceived or to have accomplished nothing. To this, of course, there can be but one answer. Dr. Biggs might have fortified his case yet more by quoting the figures recently reported by M. Pasteur to the French Academy, these namely:

Out of 529 cases of persons bitten by presumably rabid dogs, in and about Paris, who did not submit to Pasteur's treatment, 81 died.

Out of 349 similarly bitten persons treated by Pasteur, within thirty-six days of being bitten, not one died.

Out of some 450 treated, one died of the disease, which had developed before treatment, and one, bitten by a mad wolf, not a dog, died after treatment. These facts amount, in our judgment, to a demonstration taken in connection with the reasoning from the ground of probability. But there is yet another form of demonstration which is conclusive, and in this paper before us Dr. Biggs brings it out. He says at the close of it: "Pasteur's prophylactic method for rabies rests purely on empirical grounds, and can only be fairly judged by the practical results obtained by its use. So far as we know at present, these have sustained the professions of the learned discoverer, and, until they are refuted by further observations, I believe it is unjust to characterize this work of Pasteur, as has recently been done, as being founded 'on untrustworthy experiments and unsound reasoning,' deserving 'to be rejected and con-

demned in the interests of humanity as well as science.' " That some persons—a London "doctress," who wrote a most spiteful letter to M. Pasteur, was one of the most conspicuous among them—have so characterized his work is unquestioned. So late as last month Frances Power Cobbe denounced the Frenchman with great acidity of style. But a passage or two in Dr. Biggs' own paper carries with it the force of a deductive proof of the inference inductively arrived at. Pasteur's treatment of the rabic virus has been determined by the most elaborate experimentation. Nature, fairly pressed for aid, guided his master hand along lines of treatment that ran indubitably parallel with methods employed in the resolution of the silk worm and cattle diseases into germs. All the processes into which endless experiment has been directing him are processes which presuppose the existence, not only of a distinct virus of rabies, but a virus that partakes of the quality of a germ belonging to the same order, to put it roughly, with the diphtheria and small-pox germs; a fungus, in point of fact, which propagates itself by subdivision into spores, which in time, by this process of compound multiplication, number billions. This was so obvious that all critics, big and little, began hunting through their soup nurseries and spinal-cord specimens for the implied germ, just as all the unknown astronomers hunted the heavens to find the unknown external planet which alone, Leverrier concluded, would account for the perturbations of Uranus. Because they failed to find it some of them insisted that it was not there. And because it was not there, the theory was erroneous. This declaration, of course, involves the complimentary one, namely that, if the germ was there, then all the processes of thought, reasoning and experiment which led up to his germ as the inevitable climax, must be sound.

Dr. Hermann Fol, of Geneva, according to Dr. Biggs, has recently reported to the French Academy that he has found it. And since science takes nothing for granted and conceals nothing, Dr. Fol has submitted all he knows



about it. He has measured the hydrophobia germ, which is an inconceivably small globule which strings in figure of eight groups and has a diameter of .02 of a micro-millimeter. This little creature is not visible in a microscope of 600 diameter magnifying power, and that is the reason, perhaps, why some of the human microbes who denied its existence failed to find it. Again, in order to detect it the most careful process of staining the marrow in which it lies is necessary, and that is a performance that the quacks and blacksmiths of microscopy are not capable of doing. Properly prepared and viewed through a sufficiently powerful microscope, the little object, under the wand of genius, becomes the crown of a noble life, is distinctly and objectively visible, precisely as it has been clear to the unerring eye of reason in the self-poised philosopher.

### Society Reports.

#### TRANSACTIONS OF THE CHICAGO GYNÆCOLOGICAL SOCIETY.

STATED MEETING APRIL 23, 1886.

The President, DANIEL T. NELSON, M.D., in the Chair.

Dr. John Bartlett made remarks upon, (with exhibition of specimens of)

A CASE OF DERMOID CYST COMPLICATING LABOR.—A CASE OF PLACENTA PRÆVIA IN WHICH THE PLACENTA WAS EXPANDED OVER THE ENTIRE OVUM.

Dr. Bartlett said, "I have recently seen two interesting cases of labor, and I wish to present a specimen obtained at each of these, to the Society.

The first was a case in which I was called to assist Dr. John S. Clark. The patient a primipara, about 30 years old, had been in labor under the care of a midwife about twenty-four hours. The head was making no progress, and exhaustion was approaching; about one ounce of fluid extract of ergot had been given. Dr. Clark found the head lying with the anterior posterior diameter cor-

responding with the conjugate, the parietal eminences had passed the brim. He applied an old style, high curve, Bedford's forceps, but found his efforts unavailing in causing the head to advance. He then attached his direct traction handle, and descent of the head was effected. After delivery of the head there was difficulty in delivering the shoulders. When an effort at extrusion was made, there appeared in the perineal region, between the vulva and tuberosity of the ischium, a jutting outward of the tissues in the form of a tumor. It seemed as if an obstructing body was wedged in front of the shoulders. Counter pressure was made upon the protrusion, and the delivery was completed. Following the child, came a tumor of the shape and size of a large pear, presenting at the small extremity a pedicle. It was a thin dermoid cyst containing a mass of fatty substance, embedding numberless long intertwining hairs. The tumor could not be felt during labor, and a careful inspection showed that it had not been attached to the child. It was probably attached to the uterine surface, resting between the head and the shoulders. Possibly it was the cause of the dystocia in diverting the head from an oblique diameter of the brim. Depression of the vital powers with high fever set in soon after delivery, resulting in death within four days. Dr. Clark's examinations *post partum*, detected no injuries beyond laceration of the perineum. The child was still-born."

The second case was one of

#### PLACENTA PRÆVIA.

Mrs. N., had had several children, and within eighteen months past, two miscarriages. In January last, when she was nearly four months advanced in pregnancy, I was called because of serious hæmorrhage. The uterus presented to the touch nothing peculiar, there was none of that extra development of the lower segment of the organ which is supposed by some to indicate placenta prævia. The tampon was applied, opiates given, rest enjoined, and the the bleeding ceased. At four and one-



half months hæmorrhage recurred. Under treatment, the bleeding was in some measure controlled. For the two following months it was continuous, generally moderate, occasionally quite severe, at all times, as she declared four-fold greater than the flow of menstruation. I then deemed it best at six and one-half months to induce labor, but Dr. John S. Clark, in consideration of the probable non-viability of the child, advised further delay. The flow, however, was so great that the tampon was applied, and in forty-eight hours thereafter labor began.

Upon removing the plug, the os was found thin, softened and three-quarters of an inch in diameter. At about the fourth hour of labor, the os rather suddenly enlarged to a diameter of one and a half inches, and the hæmorrhage became profuse. The half hand was introduced into the vagina, and the placenta stripped off over an area, the radius of which was three-fourths the length of the middle finger. With the bullet forceps, used by me with advantage in such cases, the membranes were torn, and the opening so made was freely enlarged by the finger. Hæmorrhage immediately ceased, and labor became more active, so that in the course of an hour the child was delivered breech first. Several inspirations were made by the fœtus, a fact of interest in view of the peculiarities of the placenta, which I here present. In order to display the specimen to better advantage I have filled the cavity of the membranes with horse hair and sewed up the aperture. It will be observed that the main body of the placenta, the normal placental mass, is not prævia, but attached near the fundus and that the rare anomaly is here presented of a continuous placental tissue spreading over the entire ovum. Observe that the extra—adventitious portion, continuous with the normal placental edges, and everywhere enveloping the membranes, is comparatively thin; in the present state not thicker than one-eighth or three-sixteenths of an inch.

Dr. W. H. Byford spoke of a specimen he exhibited some time ago at the Chicago Medical Society—a dermoid

cyst which was expelled from the vagina. It was sent to him by Dr. White, of Bloomington, who said the tumor was situated in the anterior wall of the vagina, and as the child was delivered the pressure of its head pushed the tumor out before it. He thought that in the case under discussion the tumor may have been developed in the vaginal walls. The localities of these growths are not uniform and we find dermoid cysts situated in the vaginal walls. Dr. Bartlett said in answer to a question from Dr. Byford that the existence of the cyst was not discovered before but during labor; that it was beyond the head and may have been an ovarian tumor; it was not outside the vagina, but between the head and shoulders. Dr. Byford thought it almost certainly a dermoid tumor of the vagina.

Dr. W. H. Byford thought that these cases are almost always found to be in old or multiparous patients.

Dr. W. H. Byford, with reference to Dr. Bartlett's second case, asked if the hæmorrhage ceased before rupturing the membranes, or if the whole operation was done at once. Barnes claims that if the membranes are separated over the cervical zone the hæmorrhage will stop; that there will be sufficient retraction of the cervical zone to close up the mouths of the vessels. He thought it a point of interest to know whether or not that would have stopped the hæmorrhage, and whether it would not have been sufficient. He thought in that case one is not called upon to leave the membranes intact.

Dr. DeLaskie Miller said that the effect of endometritis is usually to increase the area of the development of the placenta, and he had not infrequently seen cases of placenta of the usual size, on which projections appeared in different parts in the interior of the uterus, partially connected or entirely disconnected. He asked whether a case of endometritis might not allow the villi of the chorion to form these *placentæ succenturiatæ*. He was inclined to think that that condition would encourage it. Another fact in the history of the case



that would perhaps justify this theory was the several miscarriages the patient had experienced before this pregnancy.

Dr. T. D. Fitch said that in thirty-five years of practice, in which he had probably attended more than a thousand cases, he had seen but one case in which he suspected *placenta prævia*. He was sometimes ashamed to make the statement for fear his experience had been from lack of close observation, or inability to recognize a case, but he had seen only one, and did not know that that was really a case of *placenta prævia*. He did not detect it by manual examination; the symptoms were altogether subjective. It was a seven months' labor and the child lived. There was a good deal of hæmorrhage. He had no difficulty with the labor, except from the hæmorrhage, and that did not prove serious.

The President asked if any one could suggest the origin of the tumor? Was it a twin or a dermoid thrown off from the foetus, or was it from the mother? He asked Dr. Bartlett if it was a part of the child, and was answered that after careful examination no place was found where it might have been attached. It was perfectly loose in the vagina; probably the pedicle had been ruptured.

Dr. Edward Warren Sawyer thought the case had several very interesting features, and the subject itself is full of interest. He referred to a conversation earlier in the evening in which Dr. Byford had said that he had been in practice many years before seeing a case of *placenta prævia*, and the first case he ever saw was the first of three in one night. It had happened to Dr. Sawyer to see a number of cases of *placenta prævia*. He had had two fatal cases and had learned something of early diagnosis, which had been profitable to him since, and he thought of it in the obscurity of the diagnosis in Dr. Bartlett's case. He said that in one of his cases, after reading of the ease with which one could auscultate the lower segment of the uterus under these circumstances, he prolonged his stethoscope with a long flexible tube, put a cup on the end of it and had no trouble in introducing it into the woman's

vagina. He had repeatedly detected portions of the cervical attachment of the placenta by this mode of auscultation. The remark made by Dr. Byford had received some confirmation in his experience, viz., that many cases of *placenta prævia* aborted early and that he believed this to be a frequent cause of early abortion. Spiegelberg says that *placenta prævia* is of very frequent occurrence. An interesting fact in connection with Dr. Bartlett's case was the alarming amount of hæmorrhage which took place from the placenta and placental attachment away from the main part of the placenta, or in other words, there were sinuses in the cervical zone of this uterus which were covered only by the velamentous portion of the placenta, sinuses large enough to bleed, and exsanguinate the woman. Dr. Sawyer spoke of a case to which a former pupil of his was called. A midwife summoned him at midnight to see a woman who was bleeding to death. As he entered the room she handed the doctor a cord (the child was delivered), and the placental end of the cord was a disk about as large as a butter dish. That fleshy mass had been pulled directly from the placenta and the woman was actually bleeding to death. This little mass was very thin and he was at a loss to understand what part of the placenta it could have been attached to. He delivered the woman completely and she was saved. He found the hole through the placenta corresponding to the disk which had been pulled out, it was in the thin portion of the placenta and the bleeding was somewhat alarming. Referring to the question that Dr. W. H. Byford asked concerning the mode of treatment advocated by Barnes, Dr. Sawyer said he was full of the idea, and the feasibility of it was accepted by him in his first reading of Barnes' work, and he tried to adopt it in practice, but he hoped no one would ever get himself into such a dilemma, as he was sure he lost his patient by that course. Theoretically you may detach the placenta to save the woman from hæmorrhage. The so-called cervical zone is not to be measured by the finger, he did not think it had any definite



boundaries; it might sometimes extend half way to the fundus on one side of the uterus and he thought the more we detach the more dangerous it may become. He felt quite confident that the poor woman who was the victim of the theory of Barnes would not be dead to-day if he had adopted a more rational treatment.

There was one point in connection with the causation of *placenta prævia* that excited a great deal of interest in his mind. He had seen two cases strangely confirmatory of the movement of the ovum in the early days of its sojourn in the uterus. One case was also seen by the President, but he had never spoken to him of the theory which the examination of the placenta had been the origin of. Dr. Sawyer had written to several prominent obstetricians of this country, asking if they knew anything in the literature which would answer the question: Can the ovum once attached to the decidua of the uterus become detached and again attach itself to the lower part of the uterus and go on through pregnancy? In other words, can the ovum detach itself, drop from the top of the uterus to the bottom, reattach itself in the cervical region. Many learned men replied that they had never heard of such a possibility. But Dr. Harris, of Philadelphia, hit upon this happy expression: "Rotation of the ovum." He had seen two cases in which he thought the ovum rotated in the earliest days of pregnancy; not a complete rotation, but an almost complete detachment and rolling, or rotating, downward and there attaching itself. The second case was in the practice of Dr. Doering. The subsequent examination of the placenta showed a case of partial *placenta prævia*. The umbilical cord springs from the margin of the placenta in both instances; and his theory was that in the first case, which was that of a young primipara, the placenta was fixed normally at the fundus and the cord sprang from the middle; there was a history of a sudden jar of the body when she was about three weeks pregnant; she jumped from a high wagon and immediately flowed a

little, and when she came to be delivered she had a complete *placenta prævia*. The examination of the placenta showed that the cord was attached to one margin, showing that it had rolled down and formed a new attachment for the umbilical cord. When the placenta was at the fundus and the cord at the middle, by its rolling downward it placed the cord at the margin. He thought one of the most important causes of *placenta prævia* is this rotation of the ovum very early in pregnancy; a rotation that may be caused by a sudden jar, and he thought the confirmation of it is in the unusual attachment of the cord.

Dr. J. H. Etheridge had had one case of a woman with *placenta prævia* with twins. At about the fourth month the woman fell and struck the lower part of the abdomen against the top of a wash-tub, she had a little hæmorrhage, and from that time till term she was always tender at that spot. Free hæmorrhage took place and he was called to see her. The woman was delivered of a mature fœtus, and of a child that was evidently arrested in development about the fourth month. The theory formed was that there was a partial detachment of the second placenta, the other child went on and developed regularly. The mother died in a few hours after delivery.

The President wished to say a word about the theory of causation advanced by the Secretary, the idea of displacement, or rotation of the ovum after implantation. It seemed to him that there was a more important cause, and in all the cases he had personally investigated, about four, there had apparently been good reason for the theory that disease of the uterine mucous membrane, inflammatory and with an unusual pathological amount of secretion over its surface, is the cause of the implantation at the cervix instead of at the normal place in the vicinity of the entrance to the Fallopian tube. From the quantity of the mucus the ovum glides down to the cervix and remains there, because the tissues are more healthy, perhaps. In two cases of *placenta prævia* that he had had knowledge of pregnancy oc



curred some time after treatment, with a previous history of sterility, or of miscarriage, and, possibly the mucous membrane nearest the cervix was in a more healthy condition than that near the Fallopian tubes, or possibly there was constriction of the internal os. It seemed to him there was good reason for the belief that if the mucous membrane at the fundus is not in a good condition to nourish the ovum and to hold it, it falls to the internal os and is there held, and there is a possible *placenta prævia* at full term. He wished to know if in Dr. Etheridge's case there was any previous knowledge of uterine disease. Dr. Etheridge replied that there was none, the woman was a healthy Scotch woman.

Dr. Etheridge asked whether *placenta prævia* is a common thing in animals.

Dr. Sawyer replied that he had seen a mare throw off her placenta before she threw her colt, and in fact she died without throwing the colt. He said further that he believed cervical pregnancy is generally recognized as being secondary to another thrown off from the fundus; that being the case, why not a secondary attachment of lodgment of the ovum at the lower segment of the uterus, as well as in the cervix itself. He believed the majority of authorities is against the idea of cervical pregnancy in the abstract, but he thought Dr. Bartlett considered it possible to conceive in the cervix.

The President said there might be disease of the uterus there, and then comes the question whether that is the sole, or one of the many causes. The question had been asked whether *placenta prævia* is of frequent occurrence among prostitutes; women who might be supposed to be anxious not to become pregnant, and he thought it had been answered in the negative.

Dr. Sawyer asked if the President's theory was correct and his observations had been confirmatory of it, how is it that Spiegelberg can say that many primiparæ, young, healthy women miscarry on account of *placenta prævia*.

Dr. Sawyer thought that pregnancy itself was infrequent among prostitutes.

Dr. H. P. Newman mentioned a rare

case which had lately come to his notice, namely, a complete central implantation of the placenta, in which no hæmorrhage had occurred throughout the entire pregnancy until the very last days of gestation.

Ten days prior to delivery at full term there was the first appearance of bleeding,—easily checked by assuming the recumbent posture; and it was not until five days later that the hæmorrhage became at all abundant.

Delivery took place on Tuesday, April 13th.

On the preceding Friday Dr. R. N. Hall was called, and diagnosed *placenta prævia*, using the tampon.

I first saw the case in consultation with Dr. Hall on Tuesday morning.

The repeated tamponing and use of colpeurynter the night before, had had the effect of gradually bringing on labor pains, and softening and dilating the cervix to the diameter of nearly two inches.

A digital examination could reveal nothing but a thick placental surface upon all sides, covering, as we afterwards found, the entire lower segment of the uterus.

By bimanual palpation we make out a shoulder presentation (left dorso-anterior), and decided on immediate delivery.

Every preparation being made to control hæmorrhage, the placenta was carefully separated from its uterine attachments upon the left side, and the right hand carried upward between the membranes and uterine walls.

When the feet were reached the sac was ruptured, podalic version performed, and the child extracted.

Meanwhile Dr. Hall had followed up the evacuation of the uterus by firm bimanual pressure upon the uterus through the abdominal walls.

The placenta, which was a large one, and pretty evenly distributed upon all sides, was separated from its remaining attachments, and removed as speedily as possible.

The entire procedure was accomplished in less than five minutes, and the hæmorrhage was not excessive considering the gravity of the situation.

The child was saved, and notwithstanding the amount of blood lost by the mother at and previous to delivery, she convalesced rapidly, and is now up and about.

She is a strong, healthy woman of middle age, has borne seven children, and has had three miscarriages.

With the exception of rapid child-bearing, a laceration of cervix, and one faulty presentation necessitating version, her former history has no particular interest.

In closing the discussion Dr. Bartlett said, that in a paper written years ago he had expressed an opinion that *placenta prævia* was one of the simplest of the *errores loci* of the ovum, that the true site of the placenta, when *prævia*, was the cavity of the cervix, that is, below the *os internum*, or the so-called ring of Bandl. Dr. Bartlett took occasion to emphasize his conviction of the truth of the position taken by him in the paper referred to. In the case now before the Society corroborative of his idea might be found. An ovum resting in the comparatively large cavity of the uterus would take root on the surface to which it chanced to be more nearly apposed. An ovum arrested in the much more circumscribed cavity of the neck might secure a more general, and in some rare instances, a complete attachment to surrounding uterine tissues.

#### PHOTOGRAPHING THE URINE CAVITY.—

A Swiss physician describes a plan of introducing wadding tampons and laminaria tents into the uterus, by which he has succeeded in dilating the organ to such an extent as to be able, by means of reflectors, to get a complete view of the whole cavity in cases of carcinoma, fibrous polypi, fibromata, and endometritis. Not being content with ocular inspection, he has also contrived to obtain photographs of the cavity.—*Lancet*, May 15, 1886.

The Boydston Medical Prize has this year gone to an American, Dr. Charles F. Withington, of Boston, for an essay entitled: "The Relation of Hospitals to Medical Education."—*Medical Record*.

## OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, HELD JUNE 3, 1886.

The President, B. F. BAER, M.D., in the chair.

*Dr. R. P. Harris* read for Dr. Howard A. Kelly, now in Europe, a paper entitled

GONORRHOÆAL TUBO-OVARIAN ABSCESS—  
RIGHT SIDE—LAPAROTOMY—REMOVAL  
OF THE FALLOPIAN TUBE AND  
OVARY—RECOVERY.

In this case the disease of the woman could be directly traced to gonorrhœal infection on the part of the husband, although she had never, to her knowledge, had any uterine discharge other than blood, and had always been regular in her menses during the three years of her married life.

At 14 Mrs. H. commenced to menstruate; at 17 she weighed 135 lbs., although of medium stature, after which she failed somewhat in health from an abscess of a finger, and when married at 20 was quite spare, as was also her husband, both of whom are of German blood. The husband has since reached a maximum of 167 lbs. Three years before marriage Mr. H. contracted gonorrhœa, of which he thought himself cured in three weeks. At the time of his wedding, however, he was suffering from orchitis, which he attributed to a strain, and which lasted for some time. The sickness of his wife commenced with her first menstrual epoch two weeks after marriage, at which time she had excessive abdominal pains, fever, vomiting and constipation, and was two weeks in bed, since which time she has had repeated attacks of the same kind.

She came under the care of Dr. Kelly on March 21, 1886, after having been under treatment for a supposed uterine fibroid during five months. After a month's preparation by enemata, vaginal douches and tonics, it was determined to operate upon her for the removal of a tumor located between the right side of the



uterus and the pelvis, and evidently firmly attached in its seat. This tumor had an elastic feel, had greatly affected the health of the patient by the production of menstrual prolongation and excess, and was evidently giving rise to symptoms of septicæmia.

The tumor was removed May 5, 1886, and in separating it from its bed a small cyst containing fetid pus was ruptured; this necessitated irrigation and cleansing of the viscera with hot distilled water to avoid septic peritonitis. The pulse rose to 160 the next day, but fell in four days to 76, with a temperature of 98.8°. When examined after removal, the tumor, which was about 2½ inches in diameter, was found to consist of an ovary and dilated Fallopian tube, forming a common cavity filled with from two to three ounces of thin, greenish, highly fetid pus.

A drainage tube was used for four days—the sutures removed in a week—the patient made a good recovery.

#### OVARIAN TUMOR.

*Dr. T. M. Drysdale* exhibited the specimen, and remarked: Five weeks ago I removed an ovarian tumor which, apart from the interest which attaches to each case of this kind, was personally important to me from the fact that it completed my one hundred and fiftieth ovariectomy. Twenty-five years since, April 23, 1861, I performed my first operation of this kind. At that time as you are aware, the procedure was not in such favor in the profession as it now is and the operations were few. In fact I believe I was the first after the late Dr. Washington L. Atlee who operated in this city.

My success has been encouraging. In each series of fifty the mortality has grown less and the results more and more satisfactory, but as I expect to present a report of the whole number of cases to you in a short time, I will not now anticipate what will then be stated in regard to these results further than to say that of the one hundred and fifty cases I have lost twenty.

This tumor was removed from an unmarried lady, 20 years of age, who first consulted me in February for an abdominal enlargement. She was extremely thin and delicate looking, but said she had enjoyed good health until attacked by the present disease; since then she had emaciated rapidly, her general health had failed, her stomach had become irritable and her appetite deficient. She had an unnaturally red tongue and feeble pulse which varied from 110 to 140 beats in a minute.

She first menstruated when 16 years of age, with great pain and excessive flow. Since then she had always suffered agonizing pain during menstruation, but had been regular until within the last six months; during this time she changed every two weeks flowing for two or three days. For the last month she had a thin sanguineous discharge every week.

She first noticed enlargement about eighteen months before I saw her. The whole abdomen swelled as if distended by wind for which it was mistaken, her physicians treating her for a long time for dyspepsia. The increase in size had been very rapid in the last six months. On examination the abdomen was found to measure thirty-seven inches around its greatest circumference and was distended by a tumor of irregular shape and consistence. There was dulness on percussion everywhere except in the epigastric region and over the right flank. No fluctuation could be detected except over a small portion in the left side about the level of the umbilicus, which was evidently cystic. A hard mass could be felt just below this which appeared like an independent growth. On vaginal examination the cervix uteri was found to be small and flattened against the pubic bone by a hard tumor which nearly filled the pelvis. This mass was found to be continuous with that which was felt to the left of the umbilicus. It was impossible to pass a uterine sound.

I diagnosticated a multilocular ovarian tumor. Assisted by my son, Drs. W. S. Stewart, John S. Stewart, and G. G. Chamberlain of Middletown,

Del., I operated April 28. On opening the abdomen the front of the tumor was seen to be covered by the right broad ligament, which was spread out to a great size and firmly adherent to it. The uterus was turned completely on its axis and fixed by adhesions to the left side of the growth. A large trocar was introduced but no fluid could be obtained until a cyst was reached high up on the left side. The remainder of the mass was composed of minute cysts and a nearly solid portion which was that felt in the pelvis and left side before the operation. An incision was made in the wall of the tumor, and introducing the hand, the interior was broken up as much as possible, yet it was difficult to reduce its size, and I was compelled to enlarge the abdominal incision to about eight inches in length before I could get the tumor through it. The adhesions to the broad ligament and uterus were then detached, as well as some omental adhesion; others to the wall of the right side of the pelvis still held firmly. These were finally broken down and the tumor, which proved to be of the right ovary, withdrawn. The pedicle which was very thick and vascular, was secured by ligatures. From the surface of the adhesions there was an active and persistent bleeding, which gave considerable trouble, but this was controlled, without the use of ligatures except two to vessels deep in the pelvis. After thoroughly cleansing the cavity of the abdomen and pelvis the wound was closed with wire sutures; a compress of absorbent cotton and a flannel bandage completed the dressing. I will not weary you with the details of her progress toward recovery. The only unpleasant symptoms she had were vomiting and violent colicky pains which lasted at intervals for two days. Her highest temperature in the axilla was  $101\frac{1}{2}$ . Her pulse varied from 100 to 128. She has entirely recovered and is daily gaining strength.

W. H. H. GITHENS.

Secretary.

### Correspondence.

#### THE PROPHYLAXIS OF HYDROPHOBIA.

BALTIMORE, June 22, 1886.

*Editor Maryland Medical Journal.*

MY DEAR SIR.—After reading your honest criticism of M. Pasteur's efforts at prophylaxis of hydrophobia I was at first induced, by my faith in your judgment and farsightedness, to believe with you that the fabric of his temple of fame, once so promising, is now fast giving away; but after a steady and long look through the portals of the laboratories of medicine, I am reminded that the master workmen and experimenters, who have given us most, have failed in their first efforts to convince their less favored co-workers that the treasures brought up by them from the hidden paths of science, are the ones to be accepted as worthy of place in the diadem of truth. I repeat, they have failed, as did the heaven-guided Galen fail at first to convince the medical world to accept his truth, as to the true character of the contained fluid of the circulatory system; as did the immortal Jenner fail to secure the confidence of his brethren when he, in 1798, announced that he had had a light to dawn on him, which afterwards flashed into brightness so bright that all men, even those who at first denounced his claim, hailed it as a harbinger of hope against the dread disease which so often depleted the ranks of the human family.

The first steps of the sage of "École Normale" in his dark and lonely path are trying to him; he doubtless often staggers under the weight of his responsibilities; the point of his lance is often dulled by the alluring quicksands of falsehood that beset his path and retard his progress. The cases in which M. Pasteur's prophylaxis has failed to neutralize the virus of the rabid animals, which the experimenter has so honestly given to us, are but trials of his steel, which, when most tried throws out its brightest flashes to light and leads the lonely searcher on his way to the truth. We should be most careful not to reject the



first ray emitted by our guiding star, but accept it as an element of truth, trusting that it may yet shine into the full dawn that is only preceded by the darkest hour of the night.

Although M. Pasteur has had the courage to assert that "the prophylaxis of hydrophobia is established," he is in fact but a pilgrim moving cautiously along the now dimly lighted path in search of fabric with which to build his temple of truth; fitting brick to brick for his great walls; and when he has finished the keystone of his splendid work, he will then build a temple that will dwarf all others, under whose shade his brother pilgrims may stop awhile as they pass along, and feel secure under its protection, and admire the genius of its founder.

Respectfully,

J. G. WILTSHIRE, M.D.

THE MICROBES OF PNEUMONIA.—The subject of acute pneumonia is one of those which of late has excited a considerable amount of attention, and yet, common as the disease is, it is one surrounded by many unsolved problems. Professor Weichselbaum has recently contributed to the Vienna Medical Society a paper, in which, after stating the prevalent opinions upon the nature of the affection, and dwelling especially upon the different opinions held by Friedländer on the one hand and Frankel on the other as to the precise characters and properties of the supposed bacterial agent, he relates his own experiences. He points out that clinicians are divided into two camps upon the etiological question, some regarding pneumonia as solely an infective disorder, others considering that the infective forms are different from those caused by exposure to cold. Weichselbaum, distinguishing between primary and secondary forms, divides them into: (1) lobar; (2) disseminated; (3) passive pneumonia—hypostatic, &c.,—and (4) lobular. He has examined 127 cases and instituted eighty-seven cultivation experiments, the material for the cultures being obtained one or two hours after death, as well as from the living subject, by means of a

Pravaz syringe introduced into the lung and pleura. He distinguishes four kinds of micro-organisms. The diplococcus pneumoniae is the most common, consisting of oval, elliptical, and round cocci, which occur in chains as well as in pairs. The chains are composed of from six to eight or as many as twenty to thirty cocci, are straight or slightly curved, and the cocci are enveloped in a capsule of varying thickness in proportion to their vitality. The second variety resembles the first, but distinguished by a greater uniformity in spherical shape, and in forming long and sinuous chains. The third is known as the Staphylococcus aureus s. albus. The fourth he terms the bacillus pneumoniae, consisting of rods of different lengths, the smallest and apparently youngest being oval. They have a capsule, and correspond to Friedländer's pneumococcus. The first variety was found in ninety-one cases, mostly of croupous pneumonia, also in the secondary forms. The second, or streptococcus, was found twenty times—namely, in fifteen cases of primary and five of secondary pneumonia. The staphylococcus only occurred in secondary cases, and mostly where the primary disease was due to this micro-organism. The fourth kind was met with nine times, four times unmixed with other forms. All these organisms were most abundant in the earlier stages of the disease, being scanty or absent in grey hepatisation, and, if present, staining badly or unencapsuled. At the margins of the pneumonic focus in the cedematous tissue micrococci were numerous, pointing to the cedema being not a passive process but a precursory stage of pneumonic infiltration, and resembling the invasion of cutaneous tissue in erysipelas. Moreover, inflammatory changes accompanied by these micro-organisms were found in the respiratory tract above the lungs. Secondary meningitis in pneumonia was shown to be due to the presence of the same micro-organisms, which were also found in the serous exudations of pleurisy and pericarditis, which might complicate the lung affection. The bacterial origin of the disease was therefore held to be demonstrated.—*Lancet*, June 12, 1886.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, JULY 3, 1886.

**Editorial.**

RECOVERY AFTER GUN-SHOT WOUND OF THE BRAIN.—The newspapers have from time to time mentioned the case of John Stone, a Canadian, who, in a fit of frenzy, shot his niece and then attempted to commit suicide by shooting himself in the head. Fortunately, the injuries of the young lady did not prove serious, and she soon recovered from them. The wounds of Mr. Stone were supposed to be mortal, and he was taken to his home and a guard stationed at the house. We understand that the wound was made with a pistol of large calibre, fired with the left hand, the weapon having been placed in contact with the left side of the head, a short distance above the ear. He lost much blood, and remained unconscious for some time. After having been watched by the police for a month or more, and his condition remaining so serious, as to preclude the expectation of recovery, the vigilance of the guard was somewhat slackened, and one night the prisoner managed to leave the house in company with his wife, and to escape from Canada. Some weeks subsequently he was ascertained to be in Baltimore, at the residence of a relative, having made the trip of eight hundred miles with a large bullet lodged within his cranial cavity. At several places upon the route he was so prostrated as to cause serious apprehensions in regard to reaching his destination alive. He did reach Baltimore safely, however, and after some weeks of seclusion was de-

tected by the authorities, and in response to a requisition from Canada, was placed under arrest by the local police. At this time he was examined by several medical gentlemen in order to determine whether he could be safely removed to Canada for trial. The opinion of all these gentlemen was unfavorable to moving him so great a distance, and he has remained until the present under strict surveillance at a private house in the city. His wound is located upon the left side, probably somewhat below the motor area, and there is a gap in the bone large enough to admit the end of the little finger, which is covered with a firm cicatrix, the wound having healed in a very short time. The skin is discolored from powder. The subjective and objective symptoms of cerebral injury have been very few. He complained of pain in the back of the head, running down the neck and shoulders. One pupil was dilated more than the other, and these symptoms were about all that were noted except general nervousness. An interesting point is in regard to paralysis; the injury is on the left side, and if paralysis was present, it ought to affect the right side, but as the right arm has been amputated almost at the shoulder, it is difficult to ascertain whether there is paralysis or not as far as the arm is concerned. The right lower extremity is not paralysed. As has been stated above, it is probable that the wound is below the motor area, hence no signs of paralysis were noted. It is, of course, impossible to say what has become of the missile, but it has probably lodged in the posterior portion of the cranial cavity, as a person firing a pistol with the left hand would almost certainly hold it obliquely in such a manner as to cause the bullet to traverse the cavity in a backward and downward direction. The injury was inflicted about five months ago, and we understand the patient's condition has progressively improved until the present time. The case is an interesting and instructive one, but is not unique, as quite a number of cases are upon record, where bullets have been lodged in the brain for long periods of time without producing dis-



troubling symptoms. As a rule, however, "these injuries are nearly always promptly fatal, the patient dying either on the spot from shock and hæmorrhage, or, at all events, within the first eight days from the effects of inflammation." (Gross System of Surgery, 6th Ed., Vol. II, p. 72). This case can already be classed as a remarkable one, and as an unusual exception to the usual termination of such injuries. Two questions still arise, and depend upon the future for their answer. The first is whether a fatal termination will not eventually result in consequence of the presence of the foreign body; and the second, whether the cerebral functions will not be impaired in some manner. Prof. Gross says, "a ball lodged in the brain is sometimes encysted, and may thus become a comparatively harmless tenant, the functions of the mind and body being performed with their accustomed vigor; in general, however, it acts as an irritant even when it is thus isolated, exciting inflammation, which is certain to be followed by abscess and death." Several cases are quoted in the monumental work on surgery quoted above, in which complete and perfect recovery occurred after the lodgment of bullets in the brain. One case, that of Prof. May, of Washington, recovered speedily after the lodgment of a bullet weighing an ounce, a portion of cerebral matter escaping from the wound. Dr. Wm. Lough, of Missouri, reports the case of a lady, 18 years of age, who recovered so completely that she afterwards married and bore children. A remarkable case has been recorded by Anel, in which an officer, wounded at the battle of Wagram, died at an advanced age, and the ball was found lodged in the left lobe of the cerebellum. Several instances are also mentioned by Gross when death occurred after the lapse of long periods, the foreign body having lain quiescent for six and seven years before a fatal inflammation was kindled.

We thus see that a certain number of individuals recover from gun-shot wounds of the head with lodgment of the bullet in the brain, but that it is not rare for fatal inflammation to be set up at re-

mote periods, hence a person who has received such an injury can never be considered out of danger from the foreign body until he dies from other cause. In regard to the second query, it is equally certain that changes may, and do occur, as the result of these lesions, which seriously impair the cerebral functions, sometimes producing paralysis, or spasms, or volitional or emotional aberrations of one kind or another, but whether these result from the lesions inflicted at the receipt of the injury or from the long continued presence of the ball, the references at hand do not state.

### Miscellany.

HEADACHE IN SCHOOL CHILDREN.—Professor N. J. Bystroff has examined 7,478 boys and girls, in the St. Petersburg schools, during the last five years, and found headache in 868; that is, in 11.6 per cent. He states that the percentage of headache increases in a direct progression with the age of the children, as well as with the number of hours occupied by them for mental labor; thus, while headache occurred in only five per cent. of the children aged eight, it attacked from twenty-eight to forty per cent. of the pupils aged from fourteen to eighteen. The author argues that an essential cause of obstinate headache in school children is the excessive mental strain enforced by the present educational programme, which leaves out of consideration the peculiarities of the child's nature and the elementary principles of scientific hygiene. The overstrain brings about an increased irritability of the brain, and consecutive disturbances in the cerebral circulation. Prof. Bystroff emphatically insists on the imperative necessity for permanently admitting medical men to conferences of school-boards. Of palliative measures he mentions methodical gymnastics, mild aperients in well-nourished children, steel in anæmic, bromides, inhalation of oxygen, and, in severe cases, a temporary discontinuance of all studies.—*Brit. Med. Journ.*, May 15, 1886.

WHAT IS PRECOCITY.—The question whether precocity is or is not a sign of disease ought to be prefaced by the inquiry, What is precocity? If we may venture to suggest an answer to this last query, it would be that precocity is really nothing more than early, perhaps premature, use of the higher cerebral centres, particularly those which have for their function the more active processes of ideation, and therefore generally stand in near relation to the avenues of communication with the outer world—namely, the senses. In short, precocity nearly always shows itself in one or other of the arts, much less often the sciences. Even if the higher intellectual, and in a sense inner, centres are early energised, the excitation may be traced through channels which originate in the senses. For example, the calculating boy is a being gifted with a specially acute perception of sight or sound-phantoms, more commonly the former, which are so clearly apparent to his consciousness that he works out sums mentally with the ease of an expert using slate and pencil, and adds, subtracts, multiplies, &c., with the mechanical expertness of a bank clerk. In like manner the expert with sound-phantoms may compose music or make verses. There is, indeed, no reason why the higher senses should not be brought into play at any age after the completion of the first—or is it the second?—developmental period, somewhere about two years after birth. Of course there cannot be an instant packing of the brain with records of observation or experience, but there may be almost instant brain-work of the manipulative sort—if we may so call it—after independent life has commenced. This is the point to recognise.—*Lancet*, June 12, 1886.

HOW DO PATHOGENIC MICROÖRGANISMS PRODUCE THE PHENOMENA OF DISEASE?—From the rapidity of their multiplication, it might be inferred that the symptoms and lesions of the infectious maladies are caused by the mere presence of these organisms as foreign bodies. But it has been observed that the bacilli milzbrand alone multiply in the body in

such number as to produce extensive occlusions of vessels. Further, it has been shown that no mere mechanical presence, no mere foreign bodies, aniline particles, or granules of cinnabar, ever induce the signs of fever or toxicæmia. The microorganisms of disease live in the body, and must, therefore, be nourished at its expense, whereby they withdraw from the blood or tissues elements essential for their nutrition. Pathogenic microorganisms require oxygen. In processes of fermentation outside air is excluded, in order that the germs of fermentation may be compelled to withdraw oxygen from the culture soil. Pathogenic microorganisms, multiplying in great abundance, seize upon the oxygen of the blood with such avidity as to develop, in fulminant forms, symptoms simulating those of prussic acid poisoning. But the other symptoms mentioned do not correspond either to deficient oxygenation or to carbonic acid poisoning.

These symptoms indicate toxicæmia, and since the injections of fluids from which bacteria have been separated by unglazed porcelain filters remain innocuous, it follows that the toxic agent inheres with the bacteria. Then, inasmuch as blood corpuscles show their reaction against bacteria on simple contact, it follows that the poison must lie upon or issue from their surface.

The only poisons, hitherto known, which may in such minute quantities induce such grave toxic signs are the poisons resulting from the action of the bacteria of decomposition upon organic matter. As these intensely virulent poisons were first observed only in dead organic matter, they were called ptomaines.—*Dr. J. T. Whittaker, Address in Medicine.*

SUMMER DIARRHŒA.—In the large class of summer diarrhœas of children and adults, with griping in the bowels and flatulence, the use of Listerine, in doses varying from ten drops to a teaspoonful (with or without water), has a most salutary and pleasant effect.

It can be administered at short intervals after eating, as soon as regurgitation, distention or acidity occurs. Its ac-



tion in arresting excessive fermentation is prompt, besides it exercises a decided sedative influence on the mucous membranes of the stomach.

The thymol, menthol, and boracic acid which, with the quota of alcohol necessary to their proper admixture, form the principal elements of Listerine, lend to this compound a special value in this class of cases.—*N. Y. Medical Journal*.

**SCARLATINAL NEPHRITIS.** — Scarlet fever derives most of its dangers from disorders that complicate or succeed it. Of these the most important are derangements of the kidneys, and a number of recent writers assert that these organs are constantly affected in scarlet fever. In an article on this subject, in the July number of *The American Journal of the Medical Sciences*, Dr. I. E. Atkinson, of Baltimore, maintains that future research may show that simple renal catarrh accompanies all cases of scarlatina, but it is certainly not true that renal alterations, competent to excite albuminuria or to reveal themselves *post-mortem* to reasonably careful inspection, are invariably present. Renal catarrh, however, is much more frequently an accompaniment of scarlatina than is generally supposed. It usually escapes observation, as it is only exceptionally revealed by symptoms, and can only be recognized after microscopic examination of the urine, a procedure too often neglected, but of the greatest importance as often anticipating dangerous processes that may be averted by timely treatment. Its clinical history, pathological anatomy, and most approved method of treatment, are fully considered.

**ULCERATIVE ENDOCARDITIS.**— In an elaborate study of ulcerative endocarditis, in the July number of *The American Journal of the Medical Sciences*, Dr. Byrom Bramwell records fourteen cases in all of which the aortic valve was affected, either alone or in combination, the mitral in six, and the tricuspid in one. In two of three cases in which well-marked acute and coupous pneumonia was present, he detected micro-

cocci in the exudation filling the air-cells of the lung, but he failed to satisfy himself that they were identical with the micrococci in the cardiac vegetations. The frequent association of acute croupous pneumonia with ulcerative endocarditis is a point of great interest, but Dr. Bramwell's observations on this point have not been sufficiently extensive to enable him to form a satisfactory judgment; but his pathological experience clearly shows that during certain seasons acute croupous pneumonia and ulcerative endocarditis are apt to prevail. The detection of micrococci in the inflamed cerebral meninges, and in the vessels and substance of the cerebral cortex, and the presence of disseminated patches of cerebritis and acute cerebral softening, are very interesting; and afford a satisfactory explanation of the nervous symptoms which are so prominent in some cases of the disease.

Mr. A. W. Hare, in response to Dr. Bramwell's request, undertook an experimental investigation to determine the relationship of ulcerative endocarditis to other infective conditions. The results which he obtained, and which are detailed in the paper, are, for the most part, negative.

### Medical Items.

Dr. D. Bryson, Delavan has been appointed Professor of Laryngology at the New York Polyclinic.

The *Medical Record* credits Professor Breisky, of Prague, with six Porro operations in which both mothers and children were saved.

Professor Weil, of Heidelberg, has been invited to fill the office of Director of the Medical Clinic at Dorpat.

Princeton College, at its recent commencement, conferred the honorary degree of LL.D. on Dr. John C. Dalton, president of the College of Physicians and Surgeons, of New York.

A Sanitary Convention will be held at Coldwater, Mich., under the auspices of the Michigan State Board of Health on September 23d and 24th. The programme for the convention announces an unusually large number of addresses and papers on subjects of general interest pertaining to public health.



Drs. Christopher Johnston, Frank Donaldson, H. P. C. Wilson, W. T. Howard and A. F. Dulin, of this city, will visit Europe during the present summer.

A Bacteriological department will be opened in connection with the Pathological Institute at Berlin, presided over by Professor Virchow. It is probable that Dr. Israel will be nominated director of the department.—*Lancet*.

By the lamented death of Professor Auspitz, the chair of Dermatology and Syphilis has been rendered vacant. His place in the editorship of the *Archiv für Dermatologie und Syphilis* will be taken by Professor Kaposi, in conjunction with the former co-editor, Professor Pick, of Prague.—*Lancet*.

Professor Balthazar Luchsinger, of Zürich (formerly of Berne), who died suddenly, in his thirty-seventh year, in Meran, on January 20, 1886, has left seventy-one original experimental works on physiological, pharmacological, and toxicological subjects; moreover, ten inaugural works were made under his guidance in Berne.—*Medical Record*.

Dr. Gudden, who recently lost his life in an effort to rescue King Ludwig, from drowning, is stated by the *Medical Record* to have had a collection of nearly one hundred brains, showing various atrophies, which he was intending to study. Dr. Gudden enjoyed the distinction of being a man of great administrative ability and practical sense joined to remarkable scientific attainments; a rare combination.

The Fifty-fourth Annual Meeting of the British Medical Association will be held at Brighton on August 10, 11, 12, and 13, 1886, under the presidency of Dr. W. Edwards. Dr. J. S. Billings of the U. S. Army, will deliver an address in Medicine. Dr. H. P. C. Wilson, of this city, who is a member of the Association, will attend this meeting. Dr. Wilson has found the meetings of the British Medical Association unusually pleasant and profitable and he arranges to attend them during his summer vacation in Europe.

The *British Medical Journal* says that it is officially announced that Senor Rafael Alcalde y Buril has been appointed surgeon-dentist to the infant king of Spain, whose birth lately gave rise to so much rejoicing in the Spanish capital. The *Globo* inquires, very naturally, whether the young king was born with teeth. In any case, the post of this professor of the gentle dental art, will, for some months to come, be as much a sinecure as that of the surgical instrument-maker, who was recently addressed by a country customer as "suspensory bandage-maker to Her Majesty."—*Boston Med. and Sur. Journal*.

Dr. A. M. Fauntleroy, one of the best known physician in Virginia, died at his residence in Staunton, Va., on June 19th. Dr. Fauntleroy was born in Warrenton, Va., on July 8th, 1837. He was educated at the Virginia Military Institute, and at the University of Virginia and

University of Pennsylvania. He entered the U. S. Army as assistant surgeon in 1860, but resigned his position when Virginia seceded. He served during the war as surgeon and chief medical officer on the staff of General Joseph E. Johnston, and also as medical director of the department of North Carolina. At the close of the war Dr. Fauntleroy located at Staunton where he has since resided. He has enjoyed a large practice in the Valley, and has held numerous positions of responsibility and trust. For several years he was in charge of the Western Lunatic Asylum located at Staunton. Dr. Fauntleroy was the author of a number of papers, some of which brought him considerable reputation as an original observer and careful writer. During the war he enjoyed a fine reputation as a surgeon, but in later years his labors were directed into other channels and he became more favorably known as an alienist and general practitioner. In 1882, Dr. Fauntleroy delivered the annual address before the Medical and Chirurgical Faculty of Maryland. He was subsequently elected an Honorary member of the Faculty. His death in the prime life is a serious loss to his family and to the profession.

The following sub-committees have been elected by the Local Committee of Arrangements at Washington D. C., to assist in making the meeting of the Ninth International Medical Congress a creditable affair. If the welfare of the Congress simply depended upon the liberality, zeal and hospitality of the profession in Washington its success would be brilliant, for there is greater liberality and hospitality in the ranks of the medical profession of the District to the square inch than in any city in this or any other country. The drain upon the profession of Washington in entertaining the various medical and scientific organizations which meet annually at the National Capitol is enormous. We are amazed at the generous and good-hearted manner with which it is borne by our Washington brethren.

*Local Committee of Arrangements*.—Chairman, Dr. A. Y. P. Garnett; vice-chairman, Dr. J. M. Toner; Secretary, Dr. C. H. A. Kleinschmidt; treasurer, Dr. D. C. Patterson.

*Executive Committee*.—Drs. A. Y. P. Garnett, J. M. Toner, N. S. Lincoln, C. H. A. Kleinschmidt, Chief Medical Purveyor J. H. Baxter, U. S. Army, Surgeon General F. M. Gunnell, U. S. Navy, Surgeon General Robert Murry, U. S. Army, Supervising Surgeon General J. B. Hamilton, U. S. Marine Hospital Service.

*Committee on Congressional Legislation*.—Drs. Garnett, Baxter, Walsh, Townsend, Toner, Lincoln, and Hammet.

*Committee on Finance*.—Drs. G. L. Mazruder, J. T. Young, Z. T. Sowers, J. W. Buckley, T. C. Smith, J. W. Bayne, and C. V. N. Callan.

*Committee on Printing*.—Drs. J. B. Hamilton, W. T. Hord, U. S. N., Thos. Antisell, D. P. Woolhaupter, Ralph Walsh, and H. D. Fry.

*Committee on Reception*.—J. M. Toner, S. O. Richey, H. B. Loring, I. C. Rosse, Fairfax Irwin, M. H. S. Louis Mackall, and B. O. Skinner, U. S. A.

*Committee on Entertainment*.—Drs. N. S. Lincoln, W. W. Godding, C. H. Hammett, W. O. Baldwin, G. W. Acker, D. R. Hagner, and D. C. Patterson.

*Committee on Transportation*.—Drs. J. W. H. Lovejoy, Armistead Peter, W. H. Taylor, Geo. W. Stoner, R. Reyburn, Sr., and E. M. Schaefer.

*Committee on Place of Meeting for Congress and Sections*.—D. C. Patterson, J. F. Hartigan, C. W. Franzoni, Charles Smart, U. S. A., J. O. Stanton, W. H. Hawkes, and Lachlan Tyler.



Original Articles.

REPORT OF TWO AUTOPSIES  
WHERE THERE WAS INTESTINAL  
OBSTRUCTION, WITH RE-  
MARKS.\*

BY S. T. EARLE, M.D.,

Professor of Rectal Surgery in the Baltimore Poly-  
clinic and Post-Graduate Medical School, etc.

The two following cases of intestinal obstruction seem to me of sufficient importance to bring before this Society.

CASE I.—M. M., colored, insane, female, age 69 years, for many years an inmate of Bay View Asylum. For a week before her death the patient had complained of severe colicky pains in the abdomen, which became very much distended. Death took place rather unexpectedly October 29th, 1884. Autopsy was made October 30th. The body was small, slightly built, emaciated, and the abdomen was very much distended. On opening the abdominal cavity the intestines were found much distended and of a dark red color. This was particularly the case with the ileum. On endeavoring to lift up the intestines they were found to be fixed in the pelvis, and owing to the great distension it could not be seen what the trouble was. The entire abdominal viscera with the uterus and vagina were removed from the body, and then it was found that the entire ileum from six inches above the valve had passed through a narrow opening that existed in a band of fibrous tissue passing from the left corner of the uterus to the broad ligament. In addition to this constricting band others were found, all being most probably due to an old pelvic peritonitis. The constricted portion of the intestine was very much distended, and filled with bloody fluid. Some blood was also found in the peritoneal cavity, and the entire membrane was diffusely stained. A closer examination of the bowel showed that the entire mass twisted once upon its own axis, thus effectually shutting off all circulation in the mesenteric veins. There was no ad-

hesion of the bowel or mesentery to the constricting fibrous band. There was a well marked prolapse of the vagina and uterus, the cervix uteri lying outside of the vaginal canal. The uterus was five inches long, very narrow, and its canal in places obliterated. The left corner, at which point the constricting band was attached, was very much elevated, and the opposite corner shrunk. In the right broad ligament was a cyst with smooth walls, lined with ciliated epithelium. This cyst was as large as a lemon. This mode of intestinal obstruction by the bowel passing through an opening made by a band of fibrous tissue, is by no means uncommon. Abundant opportunity for the formation of such bands is given in the frequency of pelvic peritonitis, typhlitis, and other forms of chronic peritonitis.\* Mr. Hutchinson mentions a case where the slit was formed by a false ligament being placed parallel with and close to the broad ligament of the uterus.† It may also take place by passing through rings or slits formed by loops of the intestine that have become matted together.

Dr. Quain describes an autopsy where forty inches of the ileum were found to have passed through a slit in the broad ligament.‡ In this instance, however, the gut was also held down by a band of old adhesion. Barth reports a case of strangulation of the intestine through a slit in the suspensory ligament of the liver.§ Mr. Holmes has placed on record a remarkable case where a loop of the lower ileum was strangulated through a hole formed apparently in an appendix epiploica. The appendix in question was attached to the sigmoid flexure, and formed a fatty, fibrous ring through which the loop had passed. There were several large and broad appendices upon the same segment of the colon, some of which were perforated near their base, as if they also were capable of developing into rings.¶ It may be that the appearance of the ring had been

\*All of these cases referred to were taken from Treves on Intestinal Obstruction.

†*Med. Times and Gazette*, 1858.

‡*Path. Soc. Trans.*, Vol. XII., p. 103.

§*Schmidt's Jahrb.* 96. S. 207.

¶*Path. Soc. Trans.*, Vol. XII., p. 3

\*Read before the Clinical Society of Maryland.

brought about by two adjacent appendices becoming adherent at their extremities. A peculiar mode of strangulation is by slits, or apertures in the omentum, which may be due either to congenital malformation, or, as is more usual, the result of injury. Also through the same occurring in the mesentery; these latter are most common in the mesentery of the lower ileum, are rare elsewhere, and they too can frequently be traced to injury. Several specimens in the museums of London show that the limited rent in the mesentery was the only visible lesion following violence to the abdomen.† Mr. Partridge has reported a case, which is probably unique, of strangulation of a knuckle of ileum through an aperture in the mesentery of the vermiform appendix.\* Symptoms in these cases are those of acute intestinal obstruction. In their treatment nothing short of laparotomy will afford a reasonable hope of permanent relief, and the sooner performed the better, after the diagnosis has been made.

CASE II.—J. D., white, male, age 45 years. On Thanksgiving day, two days before death, he had eaten very heartily of various substances provided for this feast day. The next day he complained of great pain in the abdomen, and in the evening was suddenly seized with collapse, from which he never rallied. Post-mortem made December 1st, 1884. Body large, strongly built, abdomen distended. Examination of the brain, cord and thoracic viscera revealed nothing of any importance. Both lungs, however, were œdematous. On opening the abdominal cavity there was an escape of gas. Intestines dark and slightly agglutinated. A quantity of pus and yellow flocculent matter was found free in the abdomen. In the median line and reaching from the ensiform cartilage to the pubis was a dark distended viscus as large as the arm of a stout man. On further examination this viscus was found to be the cæcum and part of the ascending colon, which had become bent upon itself and turned up so that the

caput lay almost touching the stomach, and was completely constricted by the sharp bend it was compelled to make. The small intestine lay beneath it and was greatly distended with gas. The ascending colon was constricted from the same cause. Perforation had taken place in the enormously distended cæcum in three places, and the gut was as thin as paper, and showed evidences of a chronic distension. On opening it a large amount of undigested food was found, raisins, currants, etc., and two large pieces of tendon, one being half as large as the palm of the hand. The man had an abnormally long meso-cæcum, and most probably from distension with gas and undigested food, it had acquired a slight torsion, and as distension continued from the fermentation that was continually going on, the constriction, both of the small intestine and colon, was made more and more complete.

This case represents a form of volvulus, that is very rare. There are two ways in which it may be produced, either by the cæcum being twisted upon itself, or being bent upon itself. In the former instance the cæcum is twisted around on its long or vertical axis, so that its relations to the ascending colon are practically unchanged. In the latter class of cases the cæcum is bent upon itself at right angles to its long axis, which inverts the cæcum, bringing the caput coli in front of the ascending colon and the posterior surface anteriorly. This last variety of cases is represented by the case just reported, except that the caput coli occupied the left hypochondriac region. There have been three of the former variety reported by Dr. Fagge in Guy's Hospital Reports, Vol. XIV., and two of the latter, one each by Dr. Fagge, reported in the same number of Guy's Hospital Reports, and Dr. Hanfield Jones, in the *Med. Times and Gazette*, Vol. I., p. 3, 1872.† In the five cases just alluded to, as in the one just reported, there was an abnormally long meso-cæcum, which may be fairly regarded as necessary to the production of

†Treves Intes. Obstruc., p. 52.

\*Path. Soc. Trans., Vol. XII., p. 110.

†See Treves on Intestinal Obstruction, p. 156.



this volvulus. Of the mechanism involved in the production of these cases generally, little is definitely known, although many speculations have been indulged in. We think, however, the explanation given of the production of the case just reported a very fair inference. Since the occurrence of this case at Bay View, the meso-cæcum of all cases autopsied has been examined, and in but one instance has been found of sufficient length to enable the cæcum to assume such a position. The symptoms of volvulus of the cæcum, will be seen by reference to the five cases just alluded to, which include examples of an acute, subacute and chronic case. Distention of the abdomen, generally of an irregular character, was constant, and in every case the cæcum was enormously distended. In the treatment of these cases, as in those of obstruction by bands, laparotomy offers the only rational hope for permanent relief.

### Society Reports.

#### THE CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JUNE 4, 1886.

Dr. Geo. Thomas and Dr. N. T. Carswell were elected to membership in the Society.

*Dr. Saml. T. Earle* then read

A REPORT OF TWO AUTOPSIES WHERE THERE WAS INTESTINAL OBSTRUCTION.

*Dr. John Chambers* thought *Dr. Earle* had made a valuable point in calling attention to the variation in the length of the mesentery in different persons. He thinks volvulus or hernia is rarely or never seen in persons with short mesenteries, at any rate, he has always failed to produce a hernia in the dead subject where a short mesentery existed, while in the opposite condition of affairs his efforts were successful.

*Dr. Randolph Winslow* thinks a right colotomy would have been a better suggestion than laparotomy, in *Dr. Earle's* second case.

*Dr. Saml. T. Earle* in closing the discussion said the reason for the gut not

collapsing when perforation occurred, was that it took place at a point where the gut was pressing closely against the abdominal wall, and this interfered, of course, with any escape of the contained gas.

#### CANCER OF THE STOMACH.

*Dr. John Chambers* showed a specimen of cancer of the stomach from a man æt. 65 years. For about a year he had suffered only from the ordinary symptoms, but lately he was troubled with most intense nausea and vomiting. Four months ago *Dr. Coskery* diagnosed cancer of the stomach, and his opinion was verified at autopsy.

There were metastases in the liver, but no disease immediately about its porta. There was no dropsy. The peritoneal cavity, especially its pelvic portion, was studded with carcinomatous nodules. The growth involved the central area of the stomach slightly nearer the pyloric than the cardiac extremity. It gave to the organ an hour glass shape.

He also showed the head and about four inches of the shaft of the femur that he had resected from a boy aged nine years. The patient had suffered from a suppurating arthritis for two years. The portion of the shaft presented was removed without difficulty, as it lay loose in the periosteum.

#### OBSTRUCTION OF THE TRANSVERSE COLON?

*Dr. R. G. Hall* asks the opinion of the Society upon the following case:

A man in whose left hypochondriac region there is a smooth, resonant tumor, not painful upon pressure. The man has no fever, and complains only of a burning sensation at the seat of the enlargement. This burning is relieved by vomiting. He is constipated and has a passage from his bowels only when purgatives are employed. One week since he became very much collapsed, but rallied and is now much improved.

*Dr. J. Edwin Michael* said under the circumstances any opinion that might be advanced could be nothing more than a guess. But he would venture as a guess that there is an obstruction in the

transverse colon on left side, and that the swelling is the result of the bowel distention, and brought about by this obstruction.

*Dr. Saml. T. Earle* said the evacuations from the bowels in these cases should always be examined, as they often shed much light upon the existing condition. He referred to a case of unsuspected cancer of the rectum that he had recently diagnosed by the contents of the gut, the seat of disease being too far up to be reached by the finger.

*Dr. J. H. Branham* referred to a case of fecal impaction that had been mistaken for constriction.

#### NÆVUS OF THE TONGUE.

*Dr. J. Edwin Michael* was recently called upon to remove a nævus from the anterior extremity of the tongue of a young lady. He employed the plan of cutting off the blood supply by a double silver wire ligature placed at its proximal side. On the second or third day it looked as if it was about to slough, but on the sixth day there appeared a rosy zone of healthy looking tongue tissue around the sloughy looking nævus; closer examination revealed the fact that the wire had cut through the tissue of the tongue at its outer edge, and the portions thus incised had united and circulation was established. From present appearances the nævus will slough out, leaving a ring of healthy tongue tissue.

*Dr. G. H. Rohé* suggests electrolysis in these cases.

#### LAPAROTOMY PERFORMED UNDER COCAINE.

*Dr. L. McLane Tiffany* said he was recently called upon to do an abdominal section, and it occurred to him to use cocaine as a local anæsthetic. He cut off the circulation from the line proposed for the incision by pressing upon the abdomen a wire pessary covered with rubber and bent in the shape of a long narrow rectangle, which would enclose the line in which he proposed to cut. After the circulation was arrested he injected along the line about 3ss of a four per

cent. solution of cocaine. The incision when made was painless until it was extended beyond the line of injection of the salt, when the patient complained of pain.

His second case, in which he employed it, was in an amputation of the penis for epithelioma of the glans. The circulation was arrested by constricting the organ at its proximal end. A four per cent. solution was then injected and the operation completed without pain, except when one vessel was being tied, when some discomfort was complained of.

*Dr. J. Edwin Michael* has used cocaine with most happy results in the smaller surgical operations, and especially in the lesser genito-urinary operations. One of its most effectual fields for action is in the arrest of hæmorrhage from mucous surfaces, and especially when occurring in the nasal cavity. He related several cases of extreme hæmorrhage from the nose that had been instantly checked by the application of pledgets of cotton soaked in a four per cent. solution of the drug.

The Society then adjourned to meet the first Friday evening of Oct., 1886.

MODE OF PAYMENT OF FEES IN VIENNA.—In Vienna it is usual to give medical men their fees at the end of the attendance, so that when honoraria are offered the hint is understood and no more visits are paid without further request. Some time since a practitioner was sent for to see the child of a certain tailor, whom he found suffering from fever, but with no signs enabling a diagnosis to be made. The fee was given, and the doctor hearing nothing further, did not consider his services were required again. However, it was discovered by the police, shortly afterwards, that some of the children in the tailor's house were suffering from small-pox. The tailor and the doctor were both summoned, the later being acquitted, while the former, who was shown not only to have concealed the existence of the disease, but to have taken in work at the time, was sent to ten days' imprisonment.—*Lancet* June 12, 1886.



PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING HELD MAY 28, 1886.

THE Vice-President, DR. DANIEL LONGACRE, in the Chair.

*Dr. Longacre* read a paper entitled,

RETARDED DILATATION OF THE OS UTERI A SYMPTOM OF FAULTY MECHANISM, ILLUSTRATED BY PRESENTATIONS OF BROW AND FACE, ACCIPITO-POSTERIOR, TRANSVERSE AND BREECH PRESENTATIONS.

The paper will be published in full at a future date.

*Dr. Clara Marshall* reported a case of

MAMMARY ABSCESS, DURING PREGNANCY, IN A PRIMIPARA.

Lizzie H., German, æt. 27, single, domestic, pregnant, with family history of phthisis (her father and mother having died of that disease), was admitted to the surgical department of the Philadelphia Hospital January 21, 1884.

When admitted she was suffering from an affection of the right breast. Examination of the lungs revealed the presence of incipient phthisis. As the patient did not come under my care until confinement, Dr. Joseph Hoffman, Interne, kindly furnished me with some brief notes of the case, from which I now quote.

The right breast was greatly enlarged, and its appearance so far suggested malignant disease, that the idea of excision was contemplated; with this in view a consultation was held, resulting in the abandonment of the cancerous view, and mammitis was diagnosed; the correctness of which diagnosis the subsequent history justified.

Poultices were applied, and in a few days pointing occurred and the abscess was opened. Soon two or three other points of suppuration were observed and the pus was evacuated by incisions. In the meantime the breast was supported in a mammary sling. March 1st, the treatment of the case by means of com-

pressed sponge (after the method of Foster) was instituted. This treatment, for the first week, seemed to act favorably, but at the end of that time so much pain was experienced that the dressing was of necessity abandoned, and the poultices were re-applied. During the time of the application of the poultices, and subsequently, large quantities of pus were evacuated by free incisions. Adhesive strips were now applied with the effect of relieving pain, by the support which they gave, and at the same time the pressure aided in the evacuation of the pus. Within a week they were, of necessity, removed, several points of inflammation having appeared beneath them, with the production of much pain. The pain was relieved by several incisions, resulting in the evacuation of nearly a pint of pus.

Throughout the progress of the case opiates had to be used to a considerable extent; the medication also included quinine, iron, whiskey, and, later, cod-liver oil. No temperature chart was kept, but a rise above the normal was noted at intervals, coinciding for the most part with the accumulation of pus, and abating as soon as this was evacuated. The highest temperature noted was 104° F. The swelling of the breast, which began about two weeks before her admission to the hospital, the patient attributed to having taken cold, though there was no history of a chill. The patient was admitted to the obstetrical department April 23, 1884, and upon the same date, after a normal labor, she was delivered of a poorly nourished, male child, weighing 5 lbs. 12 oz. This infant was never healthy, and died May 5th (12 days after birth).

From May 1st (7th day after confinement) the treatment consisted in extending the various openings by free incisions and by packing the sinuses with lint soaked in carbolized oil. Subsequently a drainage tube was inserted into the one deep central sinus and carried down to its deepest part; through this tube a solution of corrosive sublimate (1-1000) was injected daily, the injection being continued until the solution returned free from pus. During the in-

tervals the mouth of the tube was protected by a thin layer of lint saturated with the corrosive sublimate solution. The other sinuses were also washed out and packed with lint wet with carbolized oil. The breast was firmly dressed, daily, with adhesive plaster. The pus became healthy in character, and diminished in quantity, and the sinuses healed, with the exception of the central one. The patient's condition improved, and she was able to leave her bed and walk about the hospital wards.

July 1st. The central sinus is yet unclosed.

July 14th. The breast is somewhat indurated, but every sinus is healed.

The infrequency of mammary abscess in pregnancy, as compared with its occurrence in the puerperal state, is illustrated by the statistics of Mr. T. W. Gunn, Surgeon to the Middlesex Hospital. Of Mr. Gunn's 72 cases, 58 occurred during lactation, 7 during pregnancy, and 7 in women who were neither pregnant nor in lactation. The points of suppuration, in the case I have reported, were so numerous that it would be of great interest had there been obtained an accurate estimate of their number. Velpeau records a case, which he thus describes: "The breast looks like a large sponge impregnated with pus, or like the nozzle of a watering pot, there being fifty apertures for the escape of pus."

Apropos of the suggestion of malignancy, early in the case, I again quote Velpeau, who says: "Such a mistake was committed a few years ago in one of the great hospitals of Paris, by one of the most eminent experienced practitioners." Sir Astley Cooper reports a similar case, and says: "I could point to other cases." This mistake is more liable to occur when the abscess is *chronic* in character.

#### DISCUSSION.

*Dr. Samuel Longacre* said that he was in the habit of using Billroth's method in the treatment of mammary abscess: "Open every sinus freely, clean out the necrosed tissue, wash out the sinuses, and then apply an antiseptic dressing."

*Dr. Susan P. Stackhouse* reported the case of a mammary abscess in an unmarried, non-pregnant woman.

C. M., æt. 20 years; right mammary gland twice the size of the left; very painful; fluctuation easily detected. The patient was very much excited, and when told it would be necessary to lance the breast, made considerable resistance. Finally, she allowed the abscess to be opened, and a free flow of pus followed, after which there was great relief. The subsequent history of the case was without interest. The abscess had been developing for four weeks, and the patient's friends told her that it must be a cancer. There was no pain in the part until the fourth week, the swelling being the only symptom. The patient was thoroughly examined, but no symptoms of pregnancy could be detected.

*Dr. Calista V. Luther* mentioned a case of threatened mammary abscess in a male, which was aborted by means of the use of bandages and cold compresses.

*Dr. Mary Willets* related a case which had come under her observation. The patient would not permit the lancet to be used, as a consequence the abscess had opened spontaneously in *four* separate places; from each of these there was a free discharge of pus and milk for some days. At present there is no discharge of pus, but the milk is flowing freely all of the time, the patient's clothing being kept saturated. The breast was bandaged with strips of adhesive plaster, having in view the bringing of the edges of the sinuses in contact, and hoping to hasten their union in this way, but in a few hours these strips were entirely loosened, owing to the flow of milk.

*Dr. Willets* asked if the members of the Society could suggest any means by which to hasten the healing of the parts. It is not desirable to *arrest the secretion* of milk, as the patient has an infant three months old.

*Dr. Mary E. Allen* suggested compression of the gland by means of the rubber bandage. She spoke of a case of her own where firm compression was made by means of the bandage, and no milk came into the gland.



Dr. Daniel Longacre referred to Dr. Philander Harris' plan of "The treatment of Mastitis by Bandaging and Rest," an account of which appeared in *The American Journal of Obstetrics*, in the January and February numbers for 1885.

Dr. Clara Marshall would suggest the use of compressed sponge, in the case mentioned by Dr. Willets. By applying the sponge dry, securing it firmly by means of a rubber bandage, and then moistening it, the swelling of the sponge, caused by the moisture, causes great pressure on the gland which will bring the edges of the sinuses together, and thus hasten union, in this case the flow of milk would be apt to produce enough moisture. In a chronic abscess, where there is no pain, compressed sponge acts very nicely.

MARY WILLETS, M.D.,  
Recording Secretary.

## COLLEGE OF PHYSICIANS OF PHILADELPHIA.

STATED MEETING HELD MAY 5, 1886.

The president, Dr. S. WEIR MITCHELL, in the chair.

### REMARKS ON PARASITES AND SCORPIONS.

Dr. J. Leidy remarked: I have recently received for examination, from Dr. W. T. Belfield, of Chicago, three little nematoid worms, which, as stated in the letter accompanying the specimens, were referred to him by Dr. R. W. Gelbach, of Mendota, Ill., who found them in the intestine of young anæmic, but otherwise, healthy cats. Both gentlemen believe them to be specimens of *ancylostomum duodenale*, and my examination has confirmed this opinion. On superficial inspection I supposed the worms might belong to *strongylus trichosporis*, a closely related parasite infesting the cat. The specimens, however, exhibit the same structure of the mouth as is described in the *A. duodenale* of a man. Beneath the upper lip are four strong recurved hooks and

within the lower lip a pair of hooks. The finding of this parasite in the cat in this country renders it probable that it may also infest man with us, and is probably one of the previously unrecognized causes of pernicious anæmia. The occurrence of the same parasite in the cat is also of interest, as heretofore it has only been noticed in man.

I take the opportunity to exhibit several excellent photographs of trichina in the flesh of the pig and in that of a young woman, sent to me by Mr. Eugene A. Rau of Bethlehem, Pa. The photographs were accompanied by a letter giving an account of four cases of trichinosis which recently occurred in a family of that town. The pig used was raised at home and was stated at no time to have exhibited signs of being unwell. Two other hogs, raised on the same place, were examined and found not to be infested. Of the four persons infected, the mother, aged thirty-seven and daughter aged thirteen, died, while the father and a younger daughter were recovering. The photograph of the pork section exhibits many coiled worms encysted; those from the deltoid muscle of the girl exhibit numerous coiled and a few extended worms, lying loose among the muscular fibres. Dr. Leidy also read a letter from Dr. V. Gonzalez, of Durango, Mexico, reporting the great prevalence of scorpions in the district, and the frequent fatality of their sting, especially among children, who die in a short time in convulsions. Dr. Gonzalez observes that a bounty is paid for the scorpions, and that some years over 100,000 are destroyed, but they still continue to be abundant.

### DISCUSSION.

Dr. W. T. Forbes said: With reference to the second statement with regard to trichinosis, I would ask Dr. Leidy if the description which he gave of the trichina being found in pork, which is contained in the communication which he read before the Academy of Natural Sciences some forty years ago, was not the first description of the parasite being found in an article of diet? I ask

this question because it has been repeatedly stated in Berlin that the trichina had been found there prior to that time.

*Dr. Leidy*: I believe that mine was the first notice of the parasite occurring in the pig. It had been previously discovered in man. I was led to find it in the pig after having seen it in man. Dr. Goddard noticed it in a subject in the dissecting room, in this city, several years before I observed it in the pig. The parasite was at first considered to be of no importance. Some years later in an epidemic of trichinosis in Germany, the parasite was discovered in many of the persons affected and in the meat that had been eaten. I think that it was Leuckart who made some experiments and referred to my notice of the trichina in the hog. The parasite was first discovered in man by Sir James Paget.

The President, *Dr. S. Weir Mitchell*: Is there anything known of the steps by which this worm referred to in the first communication finds entrance into the system of man, and of the way in which it is supposed to give rise to anæmia?

*Dr. Leidy*: It is supposed that the anchylostomum gains entrance to man through the drinking water and if that is the case, the cats probably obtain it in the same way. If cats, in this country, obtain it from drinking water, it is probable that with us man may do so. It is curious that it should be found in the cat. Generally we find that similar parasitic worms are found only in animals closely related to one another. So far as we know, the ascaris vermicularis occurs in no other animal than the races of men. The cat has its own ascaris and this is found in various species of cats all over the world. There is another found in the dog which is also found in the wolf. Again, the ordinary tapeworm of the dog is found in all sorts of dogs. I have a specimen from the wolf in the West and I have another which Dr. Kane obtained from an Esquimaux dog in the North. As I have said, worms of the same species in the same stage usually infect only animals which are closely related.

## BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD MAY 10, 1886.

The Vice-President, Dr. A. F. Erich, in the chair; J. M. HUNDLEY, M.D., Secretary

### HEPATIC ABSCESS.

*Dr. I. E. Atkinson* reported the case of a young man, aged 26, farmer by occupation. Before coming to the hospital he had suffered from malaria at various times. These malarial attacks were accompanied with abdominal pain, vomiting and jaundice. When admitted into the hospital he was in a typhoid state; had jaundice and vomited a great deal. For the first few days his temperature was rather above normal, but subsequently it was mostly subnormal. Area of linear dulness exceeded by two fingers breadth the lower rib. He never had dysentery. The diagnosis laid between cancer of the stomach with secondary deposits in the liver, and hepatic abscess. In making a more thorough examination and weighing all the facts in the case, it was finally decided that he was suffering from hepatic abscess. Aspiration was decided upon, and done, but no pus was found; on withdrawing the needle there adhered a substance resembling very closely liver structure—a second puncture was made in another place and still no pus was found; but in making a third there adhered to the needle a granular matter. This granular matter is often seen in abscess of the liver. On the following morning a fourth attempt was made to find pus, but without success. He died in thirty-six hours of progressive failure. The post-mortem revealed an apparently healthy condition of the lungs, intestines, and heart. The liver was permeated by small abscesses; only one could be found circumscribed, and it was at the portal fissure. Dr. Atkinson, in commenting on the case, said he was convinced that abscess of the liver with us was unlike tropical abscess and that the word *tropical* as used in



this country was a misnomer. In speaking of the probable cause of the abscess in this case, he said, there was no history of injury, pyæmia or dysentery. He had had within a year, three cases of hepatic abscess, two of which came from malarious districts and had had ague and fever, but strange to say the spleen was not involved in either case. The doctor does not believe this case due to malaria, injury or dysentery.

*Dr. J. W. Chambers* asked how long since the man suffered from pain, jaundice, etc.

*Dr. I. E. Atkinson* said he had had several attacks within a year, the last spell lasted two months.

*Dr. R. H. P. Ellis* said he would like to know of *Dr. Atkinson* if he did not think the two last attacks of catarrhal jaundice had something to do with the formation of the abscesses.

*Dr. I. E. Atkinson* said of that he did not know; he was sure he fully recovered from each attack till the last.

*Dr. J. W. Chambers* said the case reported by *Dr. Atkinson* was filled with interesting points. He thought abscess of the liver much more frequent than it appeared to be; in making post-mortems he had frequently found them when no symptoms during life pointed to such a condition. He was not so sure that malaria was not a factor at times in producing the trouble and did not see why frequent congestions from whatever source would not cause abscess; we have them elsewhere, and did not see why we should not have them in the liver. In making the diagnosis we should not depend too much upon the fact of not finding any pus, as this and other cases would show. It is the second case to his knowledge in which pus was not found and the post-mortem showed abscess of liver. An important point in the diagnosis is the very low temperature, often below the normal.

*Dr. S. T. Earle* said that while acknowledging that abscess of the liver may occur where there has been no bowel lesion, he had seen seven cases, five of which had been preceded by dysentery.

*Dr. S. M. Free* related a case of supposed

abscess of the liver. He attended a lady through a case of pneumonia and during convalescence she complained of severe pain over the region of the liver; in the meantime an enlargement was observed over the site of pain, which gradually increased in size. Pus soon began to be expectorated, and with this asthmatic attacks, which greatly complicated the case. In one of these paroxysms she felt something give way or burst and she died from collapse before she could reach the house.

*Dr. H. F. Hill* asked *Dr. Free* if the pus might not have come from the pleural cavity.

*Dr. S. M. Free* said not, as she had no pleurisy.

#### HÆMATURIA.

*Dr. J. D. Blake* related a case of hæmaturia occurring without apparent cause. The man may have this bloody urine at one time, and in an hour or so his urine may be clear; he has no pain and is apparently well. He had an attack eight montus ago which lasted two days. Quinine, iron and strychnia were given him, and the trouble disappeared and did not return for four montus, when he had another attack. He is now suffering from a third. The same treatment has been pursued in each attack save the addition of ergot. No cause can be found to account for the trouble; it cannot be from exposure, as the man is indoors most of the time. When he was first attacked no red blood corpuscles could be found in the urine, but there was albumen; in this the last attack there are both corpuscles and albumen. The urine when clear is normal.

*Dr. A. F. Erich* asked *Dr. Blake* if he had examined the urethra.

*Dr. J. D. Blake* said he had not, as he could see nothing to indicate trouble there. The blood is thoroughly mixed with the urine and there are no clots.

*Dr. J. T. Smith* asked the specific gravity and reaction of the urine.

*Dr. J. D. Blake* said it was low and slightly acid.

*Dr. J. T. Smith* said sometime since he had his attention called to a similar

case. It was in the practice of another physician. The patient a woman had suffered from bloody urine off and on for a year, still her health was apparently good. The urine was neutral, contained albumen and red corpuscles, but no casts. He suggested that there might be trouble in bladder or vagina, but there was not. She was put on nitromuriatic acid and it cured her.

*Dr. E. G. Waters* asked *Dr. Blake* if his patient showed any tendency to hæmorrhage elsewhere, tender groins, etc.

*Dr. J. D. Blake* said not.

*Dr. J. W. C. Cuddy* asked if the prostate gland had been examined.

*Dr. J. D. Blake* said it had not, as there was nothing to indicate trouble in that organ.

*Dr. I. E. Atkinson* said that these cases of hæmaturia and hæmoglobinuria were not so very rare in malarial districts. Sometimes they occur without any known cause. Hæmoglobinuria may be produced from exposure to cold, getting feet wet, etc. He has seen hæmaturia without chills, though the system is usually under the influence of malarial poison. The usual treatment in these cases is ergot, quinine, turpentine, gallic acid and tonics.

*Dr. J. E. Gibbons* asked *Dr. Blake* if his patient had not pain why did he administer anodynes.

*Dr. J. D. Blake* said that they were given to quiet the patient, as he was very nervous, and he thought perhaps by subduing the nervous condition he might influence favorably the hæmaturia.

*Dr. Henry F. Hill* read a paper on

#### THE USE AND ABUSE OF ERGOT IN OBSTETRICAL PRACTICE.

He said he would not touch on this disputed question as to its action on unstriped muscular fibres. That it is an agent capable of doing much good, as well as harm, no one can deny, and to use it intelligently, one must have a thorough knowledge of labor, its various stages and complications. He then quoted Drs. G. J. Engleman, Albert H. Smith and Joseph T. Johnson as opposed to the

use of ergot under any condition during labor, that it was never called for, and usually did harm when used. The trustees of Bethesda Hospital, in Dublin, have prohibited the use of ergot until after delivery. Barnes in his latest work on obstetrics warns us to be sure as to the condition of labor; to be sure there was no marked rigidity along the tract, no distention or contraction of the pelvis, no disproportion or malposition of the fœtus, or other obstructive complication before using ergot. The doctor admits there are many objections to the use of ergot—a case once entrusted to ergot is beyond our control. Ergotism, like strychniaism will run its course in spite of all we can do. Chloral, nitrite of amyl, and physostigma all may be tried, but will usually fail. The contractions produced by ergot are not rythmical, as are natural labor pains; resemble more the contractions of tetanus. These tetanoid contractions make it imperative that the child must soon be delivered, or it must die; therefore the greatest circumspection must be observed in the giving of ergot. The doctor said that from such an array of testimony in opposition to the use of ergot, there would seem to be no condition of labor in which it could be used with advantage. He could not believe such to be the case and said, with a cervix thoroughly dilated, the vertex presenting, but lying loosely within the cervix, easily rotated or elevated by the examining finger, the lower parturient tract spacious and lubricated, and yet no effort of the uterus to expel its contents. In such a condition fifteen drops of the fluid ext. of ergot will induce natural rythmical contractions which will be followed by a speedy and safe delivery of the child, and save much time both to doctor and mother. Cases of partial inertia in which small doses of ergot may be used with advantage are by no means rare; the only prerequisite for its use, is a thoroughly dilated or dilatable cervix, and no disproportion of fœtus and outlet. The doctor thought ergot of great value in placenta prævia. It should be given in twenty to thirty minum doses sufficiently long to insure its fullest effect, before detach-



ing the placenta, and bringing down a foot or vertex. By so doing the part presenting is held in firm apposition to the sides of the uterus, and thereby preventing hæmorrhage. Administration of chloroform, application of instruments or turning should be preceded by a full dose of ergot. He said he gave it invariably as the head of the child was about to emerge from the vulva, and he believed it did good in assisting to expel the placenta, and maintaining firm contractions of the uterus, thereby preventing after pains and post-partum hæmorrhage. He also uses ergot in half drachm doses for a week after delivery to ensure thorough involution of the uterus, and to prevent retention of the lochia, which greatly lessens the chances of auto-inoculation. There is another condition in which ergot is of much value, and in illustration, I will give the history of a case occurring in the practice of Dr. J. M. Hundley. The patient had been pregnant five months when seen by Dr. Hundley, but a month or six weeks prior to calling on him she had consulted another physician, believing the child dead, as she had not felt it move for some weeks and her abdomen had begun to decrease in size. When visited by the doctor she complained of feeling generally bad, had fever, loss of appetite and inability to move about. Thinking her statement true an examination *per vaginam*, was made, and there was found extending from the cervix a lot of offensive matter. Ergot in thirty minum doses was given her and in a few hours a decomposed foetus and placenta were thrown off. She made a rapid recovery. In conclusion the doctor said that ergot was as invaluable to the obstetrician, as opium to the general practitioner, or chloroform to the surgeon.

## DISCUSSION.

*Dr. R. H. P. Ellis* said he was sure that ergot was capable of doing much good and equally as much harm. He thought it rarely called for in labor. Cited the case of a primipara he had attended; the labor was tedious, but there was nothing abnormal; the delay caused

much alarm among her parents and friends, and they asked that a consultation be had with their old family doctor. On his arrival he advised 3i doses of ergot; Dr. Ellis opposed it, and compressed on twenty minims. It soon took effect and she was thrown into violent nervous spasms, necessitating instrumental delivery under chloroform. In slow or difficult labors he would sooner trust to forceps than ergot. There is a use to which he had put ergot and found it of value, *i. e.* threatened abortion. It will not do, however, to use it indiscriminately; he has found it useful only in the weak and anæmic. Opium is better in the robust.

*Dr. E. G. Waters* spoke of a case occurring in Dr. P. C. Williams' practice, which was reported before the Obstetrical Society of Baltimore. It was a case of profuse hæmorrhage occurring on the fifth day after delivery. The bleeding was soon arrested by hypodermic use of ergot.

*Dr. J. D. Blake* said he did not see why Dr. Hill gave ergot for after pains; he thought it would rather increase the pain by causing the uterus to contract.

*Dr. S. M. Free* said that Barnes gave ergot and digitalis daily, for ten days after confinement to favor involution and guard against septicæmia.

*Dr. A. F. Erich* said that he did not wish to be misunderstood in the matter of giving ergot in threatened abortion. He only gave it to arrest the hæmorrhage; when it ceased, he discontinued its use. In using ergot after labor he was satisfied he had prevented septicæmia, but feared he had done more harm than good, for he had frequently found his patients feverish, restless and having pain; the ergot was discontinued and they rapidly improved.

*Dr. H. F. Hill* closed the discussion by saying he gave ergot to prevent septicæmia, and subinvolution of the uterus. He doubts if ergot ever does harm when properly used.

President Cleveland has vetoed the bill legalizing dissection in the District of Columbia on the ground that the bill failed to provide sufficient safeguards against the delivery of bodies to unauthorized persons.

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BALTIMORE, JULY 10, 1886.

**Editorial.**

CLASSIFICATION OF BACTERIA.—The *Medical News* (June 19th) contains the first of a series of Bacteriological Notes by Dr. George M. Sternberg, U. S. A. The author begins his remarks by calling attention to the advances made in this line of work since the introduction of the valuable "plate method" for cultivation and isolation of bacteria, suggested by the eminent savant, Dr. Koch, of Berlin.

There is no doubt but that this most ingeneous device has had more influence in placing bacteriological research upon a strictly scientific basis than any, or all of the methods heretofore adopted. By it, we are liberated in a great measure from the former absolute slavery to precautions that the old methods of cultivation in fluid media necessitated. Its advantages are, that we are by it possessed of the power to isolate from a mass containing any number of different organisms, each representative in a pure culture. The principal involved is simply that if a mass containing a variety of different species of bacteria be introduced into a liquefied media which has the property of becoming solid when poured upon a sterilized glass plate, that these organisms will, by the increase of surface thus covered, disseminate themselves over a greater or less area and become separated the one from the other. Each bacterium will act as a centre of growth for its individual

colony and in this way we are enabled to distinguish the organism that grows in one characteristic way for that one which grows after a different fashion. By introducing a minute portion of these very small colonies into tubes containing sterilized media we have at command a means of isolating from the former heterogeneous mass, each of its constituents as a pure colony or culture.

We have now but little confidence in the published results of the old methods of cultivation in fluid media, for it is evident, that when a fluid culture became contaminated by some foreign organism, the only hope of the detection of its presence was in its recognition upon morphological characteristics. Morphological differences are in most cases sufficient to enable us to distinguish between a spherical organism and a rod shaped organism, but if we have a fluid culture of a spherical organism contaminated by the presence of another spherical organism, the difficulties, in fact the impossibility of separating them is plainly apparent. So that where recourse was had only to the fluid media for cultivation we feel justified in expressing considerable skepticism upon the accuracy of many of these results. Admitting that by microscopic examination we could differentiate between the organisms with which we were working and the foreigner who had intruded himself, there were no reliable means devised for again obtaining the original organism pure.

Dr. Sternberg next gives a brief resumé of the classifications of bacteria. He mentions especially that of Cohn and that of Zopf, giving a preference to the latter as being preferable to the former as a working classification, although here he thinks it open to objections. We fail to find any mention whatever of the arrangement suggested by Hueppe. This latter classification is a natural one and has met with such favor as to merit adoption by some of the most prominent workers in this field, especially the German investigators. As a working classification we deem it of sufficient value to merit consideration, and take the liberty of giving it as suggested.



It will be seen that he divides micro-organisms into three grand divisions, and each division is sub-divided into its several genera.

#### Natural Classification of Hueppe.

- (1.) *Coccus* forms. { a.—division into pairs—*diplococci*.  
b.— " " chains—*streptococci*.  
Genera { c.— " " clumps—*staphylococci*.  
d.— " " fours—*tetrads*.  
e.— " " eights—*sarcinae*.
- (2.) *Rod* forms. { a.—forming endo-spores without change of shape—*bacilli*.  
Genera { b.—forming endo-spores with change of shape—*clostridium*.  
c.—forming arthro-spores—*arthro-bacteria*.
- (3.) *Spiral* forms. { a.—forming arthro-spores—*Spirochæte*.  
b.— " endo-spores with change of shape—*vibrios*.  
Genera { c.—forming endo-spores without change of shape—*spirillum*.

The convenience of such a classification to the working bacteriologist is apparent at a glance. It is rarely or never, that an organism is met with that can not be classified under the above divisions, and may further be placed into its natural place as a genus of that division.

The balance of this section the author devotes to discussing the question—whether the organisms now known as pathogenic have from the first possessed this disease producing power, or have they acquired it after development under peculiar circumstances?

He concludes that it would be premature in the present state of our knowledge on this subject, to advance a positive answer to either of these queries, but cites instances that might be taken as evidence favoring each hypothesis. In support of the former query he calls our attention to the tenacity with which an organism, known to be pathogenic, will retain its disease producing property even when carried through generation after generation. As evidence for the latter question he cites the alterations that are seen to take place in the degree of virulence of pathogenic organism when subjected to the different methods of attenuation which are at present claiming much of our attention.

The author then endeavors to point out the confusion that occasionally arises as a result of the different classifications. He cites the cases of the microbes of fowl cholera and of rabbit septicæmia, each of which we meet described by one

author as a micrococcus and by another as a bacillus. It, however, illustrates less the difficulties arising from the classifications than from an incorrect interpretation of what is seen by the aid of the microscope. This is a discrepancy that will continue to exist until morphological are abandoned for physiological characteristics. It is now accepted that in order to identify an organism not only its morphological description as accurately as is possible to give it, but the appearance of its growth and its behavior under all the artificial circumstances at our command should be correctly described. In referring to the stability of the pathogenic power possessed by an organism he proceeds:

"In general, we may say that the experimental evidence relating to the infectious diseases of the lower animals gives no support to the supposition that harmless microorganisms may acquire pathogenic power, within a brief time, as a result of exceptional circumstances in their environment. On the other hand, we have evidence that many pathogenic organisms are widely distributed in nature, and as their abundant multiplication must depend upon conditions relating to their supply of pabulum, etc., their pathogenic power is one of their fixed physiological characters. But we have also experimental evidence which shows that this pathogenic power is subject to modifications. According to Pasteur, cultures of the microbe of fowl cholera, when kept for two or three months become attenuated as regards their virulence. That pathogenic organisms may undergo such an alteration in nature's laboratory is quite probable, but this the author considers as entirely a different matter from the *de novo* acquisition of pathogenic power. He cites in support of this view the difference in the degree of virulence seen in epidemics of the same disease occurring at different times, the severity of the malady usually increasing somewhat after the epidemic has fairly begun, the first cases usually being of rather a milder form. If these epidemics are due to a micro-organism, the only grounds upon which he can account for this difference in

virulence is, that the organisms have by some surrounding circumstance become deprived of a portion of the disease producing property and their former virulence is only restored after they have run their course for a time through the living system. That an organism may under certain circumstances lose some of its disease producing power gives us no grounds upon which we are at liberty to suppose that the reverse may be the case: that a harmless organism can acquire disease producing properties."

#### BOOKS AND PAMPHLETS RECEIVED.

*A Manual of Dietetics.* By J. MILNER FOTHERGILL, M.D., Edin., Physician to the City of London Hospital for Disease of the Chest (Victoria Park). Hon. M.D. Rush Medical College, Chicago, Ill., Foreign Associate Fellow of the College of Physicians, Philadelphia. 8vo, extra muslin. 255 pages. Price, \$2.50. New York, William Wood and Company.

*Diseases of the Stomach and Intestines.* A Manual of Clinical Therapeutics for the Student and Practitioner. By PROF. DUJARDIN-BEAUMETZ, Physician to the Cochin Hospital, etc. Translated from the Fourth French Edition, by E. P. Hurd, of Newburyport, Mass. New York, William Wood and Company, 1886. Wood's Library Series for 1886.

*Dictionary of Practical Surgery.* By Various British Hospital Surgeons. Edited by CHRISTOPHER HEATH, F.R.C.S. In two volumes. Philadelphia, J. B. Lippincott Company, 1886. Pp. 1795.

*Analysis of the Urine with Special Reference to the Diseases of the Genito-Urinary Organs.* By K. B. HOFMAN and R. ULTZMAN. Translated by T. Barton Brune, A. M., M.D., of Baltimore, and H. Holbrook Curtis, Ph. B., M.D., of New York. Second Edition. New York, D. Appleton & Co., 1886. Pp. 305.

**TREATMENT OF DELIRIUM TREMENS.**—Dujardin-Beaumetz, following the example of Luton, advises the hypodermic injection of one-thirteenth grain of strychnine in alcoholic delirium. The injection is repeated at the expiration of five hours, and, if the symptoms still persist, a third injection is administered at the end of twenty-four hours. He maintains the existence of an absolute and reciprocal antagonism between the toxic effects of strychnia and alcohol. It is, however, of course impossible that strychnia should relieve the grave visceral alterations induced by chronic alcoholism.—*L'Union Médicale*, April 25, 1886.—*Med. News*.

#### Abstracts and Extracts.

**CONTAGION OR INFECTION.**—The imperfection of language is responsible for no slight amount of confusion and indefiniteness in the nomenclature of morbid processes. Perhaps the most striking instance of such difficulties is to be found in the use of the terms "infection," "infective," "contagion," and "contagious." According to the idea most prominent in the mind of a person who employs one or the other of these phrases is the significance which he attaches to it. Thus we often hear of such a malady being contagious, but not infectious; of a morbid process being infective quite apart from any notion of contagiousness. Perhaps the most common kind of distinction is that which would limit the term "contagion" to such disorders as are only communicable by direct contact, and would employ "infections" to denote those which are communicable through such media as the air, water, or soil. The distinctions thus created are, however, wholly artificial; for if we separate from the two groups such affections as cholera and typhoid, by following Pettenkofer in placing them apart as miasmatic-contagious disorders, we shall practically find that the limits between mere contagion and infection are reduced to a vanishing point. For practically even the most locally contagious disorders may be communicated indirectly, but of course far less frequently or certainly than the highly infectious diseases are. The word "contagion," then, covers them all, and the question becomes one simply of degree. The term "infective" is, however, receiving a wider significance by being used in another direction—as, for instance, in its application to such diseases as septicæmia and pyæmia to which the word "contagious" is inappropriate. When, however as, recently occurred—the occasion giving rise to some rather cynical remarks in a lay contemporary,—the notion is expressed, or rather implied, that diphtheria is not an infectious disease, we are brought face to face with the practical inconvenience of the term. Compared with scarlet fever, the virus



of diphtheria is no doubt far less easily disseminated, and, in the majority of instances, it is communicable only by direct contact. But all authorities are forced to admit that the diphtheritic poison can be conveyed aërially or by fomites, and that therefore it is an infectious as well as a contagious disease. The College of Physicians has done much to place the nomenclature of diseases upon a scientific basis; it might go further and seek to define the proper use of terms such as those to which we have alluded.—*Lancet* June 19, 1886.

DR. JAVAL ON GLAUCOMA.—The Paris Correspondent to the *Lancet* writes: Dr. Javal, the well-known ophthalmologist and director of the Ophthalmological Laboratory of the Sorbonne, recently delivered a very interesting lecture on Glaucoma, which he considers to be one of the most difficult subjects in ophthalmology. The lecturer chose this subject to demonstrate the fallacies that prevail even among specialists concerning the etiology and pathology of this affection. He remarks that the premonitory signs and symptoms are of little or no value as a means of diagnosis, as the same may be found in other affections of the eye. Even the ophthalmoscope does not render much assistance, as the excavation of the optic nerve is only produced at a later stage, and the pulsation of the central artery of the retina may be missing in glaucoma, and it has been seen in healthy eyes. And yet it is of importance that glaucoma should be early recognized and properly treated, as any error in diagnosis or treatment will inevitably lead to the most disastrous results. It is now known that expectant treatment is not permitted in glaucoma, and it is also known that the instillation of a single drop of atropine might produce irreparable mischief in an eye affected with glaucomatous prodroma. Even cocaine, notwithstanding the diminution of the compression which habitually follows its employment, might produce, in glaucomatous eyes, effects as baneful as those produced by atropine. When an eye feels hard to the touch and is accompanied with perikeratic injec-

tion, an immobile pupil and a rough and painful cornea, the diagnosis is easy enough; but it must be remembered that, in general, glaucoma sets in by alterations so fugitive that no ophthalmoscopic sign reveals its existence. If, however, a patient complains of weakness of vision, and the surgeon observes the least inequality of the pupils, or the least paresis of the sphincter of the iris, Dr. Javal cautions against the instillation of atropine or cocaine, adding that an eye affected with glaucomatous prodroma is not always hard and may not present any abnormal appearance. The halo, however, observed by the patient is a sign by which a glaucoma may be known at its onset; but, as other affections may produce these halos, Dr. Javal recommends the instillation of eserine, and if the halos disappear under its influence the diagnosis is no more doubtful. As regards the treatment of glaucoma, Dr. Javal states that the same eserine will serve to combat the accidents of the commencement of the malady, and recommends it to be used in the form of gelatine tablets, instead of collyria, as being more convenient than the latter. If, after the application for a few days of the eserine the symptoms are not completely arrested, surgical interference becomes absolutely necessary. But should an oculist not be within reach, and as every moment of delay is of importance, any medical man might afford temporary relief by making a slight incision of a few millimetres into the globe of the eye near its equator, between the internal recti and inferior recti muscles, as recommended by M. Parinaud. This little operation will permit the patient to proceed to an oculist, who ought to perform iridectomy without delay, and set aside sclerotomy, which is a useless and dangerous operation in such cases.

CHRONIC HYPERPLASIA OF THE ORAL MUCOSA, WITH CORNIFICATION OF ITS EPITHELIUM.—Dr. P. F. Harvey, U. S. A., in the July number of *The American Journal of the Medical Sciences*, describes very fully our knowledge of the clinical history and pathological anatomy

of this rare affection, which has only been recognized as a distinct morbid condition within the past twenty-five years, and reports five cases.

The cure of any well-marked case is doubtful, but Dr. Harvey's experience and study lead him to believe that the following method is best adapted to secure that end:

Idiopathic and irritative patches, usually expressive of debility, require a restorative regimen and tonic treatment. The use of tobacco in all forms should be discontinued as much on account of its general as its local effect. Alcohol should be interdicted. All stimulating articles of food, ginger, pepper, mustard, carbonic waters, hot liquids, hot solids, etc., must be avoided. General medication should simply be directed toward improving the general health, and topical applications toward keeping the buccal secretions in good condition.

Well-marked patches of *leukoplakia* should be treated in the same way, but we may in addition use weak chromic acid solutions. In addition, resort may be had to the constitutional use of arsenic, at first in tonic doses, and afterward carrying it to the point of toleration, if necessary, and not otherwise contraindicated. It should be thoroughly diluted. Weak alkaline washes should be occasionally used, once or twice daily, and it is important that the soothing and restorative plan of treatment be followed for years, if necessary.

Ichthyosis of the tongue seems to occur in perfectly healthy and robust men, and in its treatment the question of vital repair may not be one of so much importance. If the patch is not too thick, it may be first brushed with chromic acid solution, 1 : 8, or, if not likely to be benefited by that application, it may be curetted when clearly diagnosticated; it should be entirely removed by the galvano-cautery, the sharp spoon, or the knife, for otherwise its transformation into cancer is only a question of time.

**TUBERCLE BACILLI IN ADDISON'S DISEASE.**—It has long been held by some writers that the fibrocaseous change which characterises the suprarenal

bodies in Addison's disease is of tubercular nature, and the histological characters upon which this opinion rests have been strengthened by the detection of the bacillus tuberculosis in the morbid material. For this observation pathology is indebted to Herr Goldenblum, of Dorpat, in a well-marked case of the disease which he examined in 1884. The subject was a man twenty-four years of age; there was well-marked bronzing of the skin and mucous membranes, caseation of both suprarenals, general wasting, pulmonary emphysema, cloudy swelling of the heart fibres, liver, and kidneys, and swelling of the intestinal solitary glands and the portal lymphatic glands. At Professor Thoma's suggestion the diseased capsules were examined by Ehrlich's method, and large quantities of tubercle bacilli found in the caseous masses (Virchow's *Archiv.* Bd. 104, s. 393). Although Guttman in 1885, and Rauschenbach in the present year, have reported cases of suprarenal bacillary tuberculosis, yet in neither case were the symptoms of Addison's disease prominent, and both these cases must yield priority to Goldenblum's. He remarks that on the bacillary test his case goes to prove that in Addison's disease, in which the capsules are the only organs that exhibit caseation, the lesion must be regarded as a local tuberculosis, unless it can be proved that the occurrence of the bacilli is a secondary event. — *Lancet* June 12, 1886.

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### Miscellany.

**BACTERIOLOGY.**—The rapid advances of bacteriology during the last few years, and the important rôle which bacteria play both in health and disease, give great interest to a sketch of the chief facts which have been made out with regard to these minor organisms, and of the method of investigation employed in their study, which Mr. Watson Cheyne presents in the July number of *The American Journal of the Medical Sciences*. A knowledge of what has been discovered with regard to these



minute bodies is essential for the study of pathology, and for the rational treatment of infective diseases. But it is more especially in the department of preventive medicine that the practical value of these researches is as yet evident. So long as the precise cause of a disease is unknown, the views held as to its origin must necessarily be vague, and the measures adopted against it often either inefficient or excessive. But when the cause is known, and more especially when it can be studied apart from the body, its mode of entrance into the system, and the best methods of destroying it under various conditions are learned, and the measures to be adopted against it can be made precise and effectual. It is not, however, sufficient for the medical officer of health to know the literature of the subject; he must himself be a bacteriologist, ready and able at any moment to carry out an investigation on bacteria. More especially must he be acquainted with the methods of demonstrating, recognizing, and studying these organisms in water, food, etc., with the view of determining in many cases whether these substances are hurtful or not, and also with the view of ascertaining the exact source and commencement of any given epidemic. It is necessary that the practising physician also should be, to a certain extent, versed in some of the methods, more especially in those of staining and examining bacteria, as, for example, the bacillus of tubercle, in order to enable him to make or confirm his diagnosis. In surgical work, again, more especially in the treatment of wounds, a practical acquaintance with the subject is almost essential. Whatever antiseptic substance be employed, or whatever method of wound treatment be adopted, the principles enunciated years ago by Sir Joseph Lister must be rigidly adhered to; microorganisms must be completely excluded from wounds or their active development must be prevented. To do this intelligently, the surgeon must know what are the chief facts with regard to bacteria; while to carry out the wound treatment comfortably and successfully, a practical knowledge of the methods employed in

laboratory researches is almost essential. The importance of these studies will doubtless become more fully recognized as time goes on, and facilities for their study by students will be provided in every good teaching school, as is, indeed, being already rapidly done in the leading universities in Germany.

#### OLEATE OF MERCURY AND MORPHIA.—

Dr. John Herbert Claiborne, M. D., Petersburg, Va., says that during the last year he has been very much impressed with the results obtained from the use of the oleate of mercury and morphia in the treatment of acute glandular inflammation and phlegmonous inflammation threatening carbuncle. I might say in carbuncle itself; for in one or two of the cases in which I resorted to its use this disease was evidently established and unmistakable. A gentleman summoned me on the first of January, suffering extremely with a circumscribed swelling, some three inches across, just below the central portion of the left occipital bone, and extending, of course, below the line of hair. It was exceedingly sensitive to the touch; hot and throbbing. His system was in sympathy with the local disorder, and he was feverish; had foul tongue, anorexia, and restlessness. He informed me, in addition, that he was just recovering from quite a bad attack of erysipelas capitis. I directed the hair to be shaven off over the whole area of the swelling, and the following to be applied every three or four hours, rubbed in as a liniment, gently, the swelling exceedingly sensitive:

Oleate of mercury and morphia,  $\frac{3}{4}$  ss.  
(20 per cent. each.)

In the meantime I directed a mercurial laxative and chloral hydrate at night, 30 grains, or sufficient to secure rest; and a glass of bitter water every morning *pro re nata*. As the subject was a bon-vivant, I did not restrain his diet very strictly; but allowed full rations of plain but wholesome food. He suffered but little more pain; and in the course of a week the swelling had become very circumscribed, and a small portion of dead cellular tissue was re-

moved through a natural opening in the centre of the carbuncle. Recovery was rapid and complete. How does this compare with the ordinary course and result of treatment of a carbuncle, even small, on the back of the head, and that, too, in a person of sixty years of age—a man somewhat crippled in constitution by high living and self-indulgence? No cutting, no carbolic acid, no caustic potash! And a less painful course and more rapid termination of the disease!

Dr. Claiborne reports equally good results from the use of the oleate in the treatment of bubo; adenitis of children, acute or chronic, the result of local irritation, the sequel of scarlatina, or the concomitant of diphtheria.—*Gaillard's Med. Journ.*

BROOKE ON A CLEANLY AND ECONOMICAL METHOD OF APPLYING OINTMENTS.—A number of ointments, prepared with a solid base, composed of cacao-butter, wax, and oil, or lanolin, are cast into the form of sticks ("salve-sticks"). The writer had found them particularly useful in making applications to the face and hands, since, their melting point being high, they did not run at the temperature of the body, as did ointments prepared with the ordinary bases; and, when dusted over with powder, they were practically invisible. When covered with Mather's or Seabury and Johnson's adhesive rubber (water proof) plaster, they offered a mode of applying remedies to the skin which was more durable than the Unna-Beiersdorf plasters, and less expensive. With this protective covering they were especially applicable to the treatment of psoriasis by chrysarobin, and possessed several advantages over the methods of Pick, Auspitz, and Besnier, in that the fatty menstruum was preserved; they did not need such frequent renewal; they were more readily applied, and did not cause any disagreeable dragging on the skin and hairs. The fear of staining the clothing was completely removed, and the patient might, moreover, bathe without disturbing the dressing. They were supplied enclosed in small cases, like those used for cosmetics, so that they could be con-

viently carried in the pocket.—*British Med. Journ.*, May 22, 1886.—*Analectic.*

A CLASSICAL REMEDY FOR HICCUGH.—Dr. A. G. Gibson calls attention to the old Hippocratic aphorism, "Sneezing occurring after hiccough removes the hiccough," and suggest in cases of hiccough, the production of sneezing by tickling the nostrils, and he tells us that he has in this way been very successful in the arresting of this disagreeable affection. Hiccough, as well as sneezing is one of the specially modified respiratory movements, and it is quite in accordance with what we know of the transference of nervous action that the spasmodic contractions of the diaphragm should cease on the induction of the explosive expirations which constitute the acts of sneezing. There is one, point, however, which deserves special mention. It is not necessary that the stimulus applied to the nose be followed by sneezing. The application of gentle irritant to the nasal mucous membrane may be quite enough to put a stop the hiccough, by diverting the nervous energy into other channels, although it may not be of sufficient power to induce sneezing.—*The Lancet and Clinic.*

GAUTIER (L.) ON THE ABUSE OF CARBOLIC ACID.—The author in the *Rev. de la Suisse Romande*, cites many cases of irritation produced by even dilute carbolic solutions. Varicose ulcers, furuncles, small phlegmons are frequently maltreated by carbolic dressings.

In traumatisms, when the wound is not simple, when the neighboring skin is more or less severely contused, carbolic acid is often hurtful. A simple wound is, according to M. Gautier, the prime indication for the use of carbolic acid.—*Rev. de Therap.*, May 1, 1886.—*Analectic.*

ON THE EARLY DIAGNOSIS AND TREATMENT OF SYPHILIS.—Prof. Fessenden N. Otis says in the *N. Y. Med. Monthly* (May, 1886): "Initial lesions of syphilis on the integument do not exhibit a characteristic induration, as, for instance, on



the finger or on the body of the penis.

In every case when the possibility of having acquired syphilis is under consideration, an examination of the person with whom contact has occurred should be insisted on when practicable, and in such examination not only the genital apparatus, but the mouth, throat, and anus should receive careful scrutiny. Examine not only the body for eruptions, especially the scalp—not only the lymphatic glands in the groins, but in the neck and in the epitrochlear spaces. In all cases it should be borne in mind that recent, painless gland enlargements are almost certainly due to a syphilitic infection.

In such examinations it must be remembered that the late or so-called tertiary lesions of syphilis are not inoculable, and that the presence of such lesions, whether as eruptions or ulcerations, do not indicate a capacity to communicate syphilis.

In the absence of positive evidence of syphilis in any lesion following illicit contact, no internal treatment is necessary. Early decision is based not upon any one symptom, although the occurrence of any one manifestation should compel a postponement of a positive decision until the full period during which secondary symptoms might develop has passed, and this is not less than six months. A well-grounded suspicion of the syphilitic origin of any lesion should be a bar to marriage for at least three years, or to the resumption of martial relations for a period of at least six months."

**THE DANGER OF TUBERCULAR AFFECTION FROM COWS' MILK.**—Paris cows are said to have been found to be producing milk which contains the bacillus of tubercle, and the Council of Health have advised the closing of all cowsheds in the city. It is believed that the conditions under which these animals are kept have contributed to the production of this disease, and it is hoped that the milk of animals living in country farms is less open to objection in this respect. Of late years much has been done to improve London cowsheds, but the question certainly deserves consideration whether

the inhabitants of this metropolis are not exposed to the same risk as are those of Paris. At the present time there are in London more than 800 cowsheds, and the amount of milk distributed therefrom is very large. If it could be definitely shown that London milk is more prone to contain tubercle bacillus than that coming from the provinces, there would be much reason for the Metropolitan Board of Works to follow the same course as that pursued by the Paris authority. It may be found that of the evil effects of milk, of which we have heard much lately, that of the production of phthisis is the greatest; but the power which every householder possesses of protecting his family by boiling all milk which comes upon his premises is so easily within his reach that it is a matter for regret that the practice of milk-boiling is not more general.—*Lancet*, May 22, 1886.

**HUGE DOSES OF BISMUTH IN CHOLERA.**—At the Madrid Academy of Medicine Senor Sanchez, of the Military Sanitary Service, described his method of treating cholera, which consists in the main in giving huge doses of subnitrate of bismuth—150 grains every half-hour or hour—until the diarrhoea is arrested. The oil of mustard is also employed externally, and a very rigorous diet enforced, even bouillon being excluded.—*Lancet*, May 22, 1886.

**A UNIQUE COLLECTION.**—*The Lancet* says, a curious sale of skeletons is said to be about to take place in Paris. The collection belonged to a French doctor who devoted his existence to studying distorted human nature, and visited hospitals to buy up the corpses of deformed persons. By this means he formed a unique museum of abnormal skeletons, for which his heirs now ask £1200.

**HOW TO TAKE THE TEMPERATURE QUICKLY.**—This may be done, according to Dr. Fitaloff, by warming the thermometer till the mercury stands at 106° or over, then placing it quickly in the axilla, where it need remain only one or two minutes.—*Med. Record*.

### Medical Items.

The *Philadelphia Medical Times* announces that Dr. John V. Shoemaker has accepted the chair of Dermatology, and Dr. E. E. Montgomery the chair of Gynecology, in the Medico-Chirurgical College of Philadelphia.

Lafayette College, of Easton, Pa., has conferred the degree of LL.D. on Dr. Henry D. Swift, of the University of Pennsylvania, and the degree of A.M. on Dr. J. Clinton Edgar, of New York.—*N. Y. Med. Jour.*

Dr. Pozzi, agrégé of the Paris Faculty of Medicine and hospital surgeon, is charged with a mission to Germany and Austria to examine the programme and arrangements for the study of gynæcology in those countries.—*Lancet.*

Professor J. F. Harrison has resigned the chair of Practice of Medicine and Obstetrics in the University of Va. after some years of service. The name of Dr. W. C. Dabney, of Charlottesville is mentioned in connection with the vacant chair.

A bronze statue of the late Sir Erasmus Wilson, erected in the grounds of the Royal Sea Bathing Institute Margate, was recently unveiled in the presence of a distinguished assemblage. The statue was presented to the Infirmary by Lady Wilson.

The Paris Academy of Sciences having to appoint a successor to M. Desseignes, late corresponding member in the chemical section, has shown its large-heartedness in nominating in the place of the deceased French *savant* a German, Dr. von Baerger, Professor of Chemistry in Munich.—*Lancet.*

Surgeon-General Robert Murray of the U. S. Army will be placed on the retired list in August, on reaching the age of sixty-two. It is generally thought that Surgeon Baxter, who is now the senior colonel in commission, will succeed to the office. Surgeon-General Murray has made an able and popular officer. He is a native of Maryland.

Dr. W. P. Tolles has been elected to the chair of Anatomy in the University of Virginia, to fill the vacancy occasioned by the death of Professor J. Staige Davis. Professor Tolles has for some years past filled the position of Demonstrator of Anatomy in the University and his elevation to the chair was anticipated.

On the 21st of June, there was opened on Glen Island, in Long Island Sound, near New Rochelle, a "Military Camp of Instruction in Marching," under the superintendence of the veteran pedestrian, Edward Payson Weston. The competitors, who are made up of members of the various militia regiments, are each to walk twelve hours a day for six days, carrying forty and a half pounds in the way

of knapsacks and accoutrements, and the camp will be continued for nine weeks. On the opening day, an address was delivered by Professor R. Ogden Doremus, in which he referred to Weston as the father of walking in this country, stating that since 1867, he had walked 63,500 miles, and that Dr. Richardson, who examined him in London, pronounced him the healthiest man he had ever examined. He concluded as follows: "I would advise all, if they desire good health, to sweat daily as the result of physical exercise. Gentlemen, I look upon this camp as the initiative step toward splendid results in our country."—*Boston Med. and Surg. Jour.*

Professor W. H. Pancoast, who recently resigned the chair of Anatomy in the Jefferson Medical College, Philadelphia, has accepted the chair of General Descriptive and Surgical Anatomy and Clinical Surgery in the Medico-Chirurgical College of Philadelphia. The reason assigned for this change is that the last named institution is working out the problem of higher medical education by establishing preliminary examinations and a three year's graded course.

At the recent meeting of the Association of American Physicians, held in Washington, the following officers were chosen for the ensuing year: Drs. S. Weir Mitchell, President; Francis Minot, 1st Vice-President; R. P. Howard, 2nd Vice-President; G. L. Peabody, Secretary; J. T. Whittaker, Recorder. A council of seven members was also chosen; Drs. W. H. Draper, of New York; R. T. Edes, of Boston; H. M. Lyman, of Chicago; S. C. Busey, of Washington; F. C. Shattuck, of Boston; W. H. Welch, of Baltimore; William Osler, of Philadelphia.

Dr. Maclagan, the medical officer of the Hexham Rural Sanitary District, England, while calling attention to the fact that in his district 124 children out of 1000 die during their first year, attributes much of the mortality to "inflammatory diseases, cerebral and pulmonary," caused by exposure in perambulators. Dr. Taylor, of Scarborough, also lays much stress on the matter of wind-pressure to which the perambulator exposes children, in the causation of diseases of the throat and chest.—*Boston Med. and Surg. Jour.*

The Senate has passed the yellow-fever commission bill, which was urged in person by Dr. Joseph Holt, of New Orleans, in behalf of the American Public Health Association. Some opposition on the part of some of the friends of the late National Board of Health, and some sentiments of frugality, induced Congress to amend the bill so that it now provides for the detail of two officers already in the service, but with the proviso that they must be skilled in bacteriology and microscopical research. No provision is made in the bill for the appointment of a member of the commission from civil life, but the employment of experts is allowed.—*N. Y. Med. Jour.*



Original Articles.

STUDIES OF INSANITY.

BY JOHN MORRIS, M. D., OF BALTIMORE.\*

No. 1.—REVIEW OF STONE'S CASE.

It was my purpose to prepare a paper on some cases of insanity possessing exceptional features which I had met with in my own practice in past years; but the case of William E. Stone recently tried in our Criminal Court, involves so many important considerations and suggests so many questions connected with medical jurisprudence, that I thought a review of the trial at this time might prove interesting, and perhaps useful.

The history of Stone's case is as follows: William E. Stone, 46 years of age, had been married more than twenty years; his married life had been uncongenial; he was of a jealous disposition and had frequent quarrels with his wife. On one occasion, in a fit of anger, he cut to pieces a dress she had been wearing, to prevent her going out. This is the only act of violence, before the murder of his wife, which was cited in evidence. He was suspicious of his two grown daughters and believed that they were being led astray by their mother. He was not an intemperate man, though his wife it appears had accused him of drunkenness. He had, however, drank two or three glasses of beer on the day of the murder; if more, it was not shown. He had on several occasions threatened to commit suicide on account of his domestic troubles, but had been persuaded to abandon this intention by his friends. There was some history of an attack of sunstroke which occurred about two years before the tragedy. On the day of the shooting he came home about 1 o'clock and found his wife absent. He put on his gum coat and went out again. He returned between 3 and 4 o'clock, went up stairs, stayed a few minutes and went out again. After this he went to the house of John Frank where he was in the habit of drinking beer. He borrowed a pen and ink from

Frank and went over to an ice box and wrote the following letter.

BALTIMORE, November 13.

*To the Public:* As this is about my last act in this world, I will say, through a deceitful wife, led on by a mother-in-law, I have lived in hell for twenty years. Now, as my two daughters are led astray through them both, and my little ones are to have their homes broken up by a mother, aided by a mother-in-law, I can stand it no longer. I love my little ones, and I hope some charitable person will see that they are put where they can be raised in the fear and love of God, but my dying request is that none of my wife's people have anything to say in their disposition. Through their deceit they have broke up a would-be happy home. I have always provided for my family's wants, but never got any credit.

(Signed)

W. E. STONE.

In addition there was written in lead pencil:

"I have friends in this world. All I ask that they will see that my children are put where they can be raised right. A broken heated father I die to save my children."

Frank testifies that when he wrote this letter he had a worried look, indeed the testimony of several other persons who saw him on that day is to the same effect, one testified that he looked wild, another that he looked melancholy, and a third that he was self-absorbed and did not return his salutation. About 5 o'clock he returned to his home and found his wife at home. He went into the yard, remained there a few minutes, came into the house and immediately thereafter shot his wife. He then pointed the pistol at his own head, but it did not go off. He drew the trigger a second time and it did go off, he fell prostrate to the floor close to his dying wife. One of the children who witnessed the scene, testified that Stone and his wife had been talking together before the shooting, but the younger boy testified that his father did not speak to any one when he came back at 5 o'clock, nor utter any exclamation when he shot his wife. After the shooting Stone talked to officer Burns concerning the affair. He said that his wife had acknowledged to him that she was as low as she could be; that on the day of the shooting he

\*Read before the Baltimore Medical Association.

was bewildered; that he had some words with his wife, went out into the yard, came back into the kitchen and shot her.

These are all the important particulars as brought out by the State in the trial. The testimony for the defence proved good character and habits of temperance and industry.

Stone's family history as given by the defence was a most remarkable one; indeed, the behavior and mental pyrotechnics of the whole family during the trial were of the most dramatic character possible. In the midst of the proceedings on the first day of the trial Mrs. McGuire, sister of the prisoner, had an epileptic fit. On the second day his brother Charles had a similar attack and on the last day of the trial Mrs. McGuire repeated the performance of the first day. In her testimony which she gave in a very sentimental manner, she said she believed her father was crazy; that he had at one time attempted to hang himself. He also thought he was called to preach the gospel. She testified that her father was subject to fits of epilepsy and that she herself had had forty or fifty during her life, and that her mind had been affected by them. She said that her brother Charles was similarly afflicted. She also had a sister who was idiotic. This sister was called to testify, notwithstanding her idiocy, but she had hardly been sworn before she was taken with an epileptic fit and had to be removed from the court room.

Charles Stone, a brother of the prisoner, who was formerly an inmate of Spring Grove Asylum, also testified concerning the mental condition of his family. He thought his brother insane.

There was some evidence to prove that the prisoner suffered himself from epilepsy. This evidence was, however, given by his sister, Mrs. McGuire, his brother-in-law, Patrick Burns, and a certain John Cullum. These attacks could not have been frequent as he was recognized as a good workman, received the highest wages, and was constantly employed.

After the trial Stone betrayed a great deal of emotion. He wept over his children and asked for his eldest daugh-

ter Ella, who had testified against him. He embraced her fondly, saying he forgave her and her sister Clara for their testimony. In about half an hour he was placed in a carriage and taken back to the community amidst the plaudits of an admiring crowd.

Five months before this strange scene occurred, in the Central Criminal Court, London, Henry Patrick, aged 24, an epileptic, was put upon his trial, convicted without remark by the jury, and sentenced to death, for the "wilful" murder of Rachel Bayley. During the progress of the trial the wretched man was seized with a violent epileptic convulsion which interrupted the proceedings for about a half an hour; he was again seized in a similar fashion at the conclusion of the sentence. The counsel for the defence stated that his client had been suffering for some time from epilepsy, and urged that he should not be held responsible for his acts. Dr. Morgan, of Clerkenwell Prison, stated in evidence that although the man had had several epileptic seizures, he, nevertheless, considered him to be a man of sound mind and understanding. The London *Lancet* discussed this case, and following its advice the Government granted a reprieve and Patrick's sentence was changed to penal servitude for life.

Now let us examine this case of Stone and see if *he* can be considered a man of sound mind and understanding at the time he took the life of his wife.

Stone was a married man and the father of a number of children, all of whom were healthy in mind and body. Four of these children testified in the case. The evidence shows that he was an industrious and expert workman, that he always found employment and obtained good wages. His employers state that he was a man of good temper and average understanding. They had no reason to suppose that he was of unsound mind. It is true that a person may engage in the ordinary affairs of life and display a fair amount of intelligence, and yet have moments of insanity when his reason is powerless to control the action of his animal instincts, but we can discover no such condition in Stone's case.



There is no evidence that the machinery of his mind was radically deranged or that he was suffering from a disease, attended by fits of distinct mania. There were no outbursts of passion, no demonstrations of violence at any time, save in the single instance when he is said to have cut his wife's dress to prevent her leaving home. There is no history of delusions, irascibility of temper, moodiness or of fixed melancholy. To constitute insanity there must be some proof of deviation from the normal structure, some radical defect that interferes at stated periods with the natural movement, not only of the brain, but of the whole nervous machinery by which thought, speech and action are maintained and controlled. A man who suffers from a disease which clearly and without a doubt implies that his brain is more or less damaged should not be held responsible for his acts, but the proof of the existence of such disease must be drawn from his every day conduct and the whole tenor of his life. The history of epilepsy in his family and other aberrations which were stated to exist led of course to his acquittal, but let us inquire how far epilepsy was a factor in the case. There is a form of epilepsy called automatic in which persons afflicted perform intelligent, and even difficult, acts unconsciously, but certainly no one will contend that Stone suffered from this form of epilepsy at the time of the murder. No man ever procured a pistol and loaded and discharged it unconsciously under the influence of an epileptic seizure. Time and deliberation are both necessary for an act of this character, and consequently the theory of impulse or unconsciousness must be excluded in this case. A man may commit a murder in a paroxysm of epileptic fury. This is an impulsive fulminant form of madness, the result of previous disease. To constitute insanity you must have defects of intellect, as well as obvious perversions of emotion, though it is not always necessary to connect the outburst of passion with the mental aberration. There are no centres of emotional impulse. Every emotion is a process of nerve-change and to maintain a theory

of insanity some intellectual defect which lies at the foundation of the patient's character must be proven.

The celebrated case of the Rev. Mr. Watson in England some years ago was very similar to that of Stone. Notwithstanding the opinions of Dr. Joseph Rogers and Forbes Winslow, who testified that Watson was insane, he was convicted by the jury and, even after an examination ordered by the Home Secretary, he was (with the concurrence of the Lord Chief Justice and Mr. Justice Byles) condemned to penal servitude for life. Mr. Watson was an old man; he was out of employment and saw before him no hopes of obtaining a living. He suffered from a profound melancholy, but he bore all his troubles and his marital provocations patiently. From the time he lost his situation his character seemed to be perfectly unhinged. His melancholy was of such a character as to prevent him from attending to his ordinary duties and he was often seen walking about the neighborhood of his home talking loudly to himself, etc. When he killed his wife he did so with the utmost ferocity. After the fatal act he betrayed a real intellectual incapacity to apprehend either the true nature of his act or its probable consequences to himself. Forbes Winslow in reviewing the trial says: "The case of Mr. Watson, was, to my mind, clear and unmistakable, and if the term 'melancholia' had not been introduced into the argument, I believe the jury would have had no difficulty in acquitting him on the ground of insanity. Judging by Mr. Watson's antecedents, as detailed on the trial, but more particularly as deduced from facts that have come to the knowledge of the public since his condemnation, I am of the opinion that the great mental distress and anxiety to which he was exposed in consequence of his loss of situation, income, and social position, associated with his deep domestic sorrow, which induced a state of profound despair, had seriously damaged his brain, and ultimately also affected his mind, and that, although in all probability ordinary observers did not notice in him any well-developed symptoms of insanity

(and how often this is the case?) previously to the murder, the germs or elements of mental alienation were no doubt in existence, and the train of powder was laid, ready to be ignited directly the torch (and exciting cause) was applied. I believe that in Mr. Watson's case the violent quarrel he had with his wife, the last no doubt of a series acting upon an intensely overwrought, and probably *congested* brain, rendered by a severe strain to which he had been exposed acutely susceptible of morbid exaltation, developed a *sudden burst of maniacal frenzy* (not ordinary anger as understood by the words, '*ira furor brevis est*'), and that in a state of *paroxysmal madness* (utterly destroying his capacity to distinguish between right and wrong) which this induced, committed the murder."

Several medical witnesses in the case testified that they had never known an instance of homicidal insanity which had not been preceded by evident symptoms of disordered mind. This declaration told fearfully against the prisoner, and in a measure secured his conviction.

Forbes Winslow commenting on this says: "Is not medico-psychological literature replete with the history of cases in which impulsive insanity or 'murderous madness' has *suddenly* developed itself when no symptoms of mental alienation were—although in all probability existing—previously *observed*? Similar phenomena are common in cases of suicide. Under the head of 'transient and impulsive insanity,' as described in the leading psychological text-books, instances of this kind are related." But in Stone's case we have no evidence of any outbreak of passion, no "murderous madness" or "impulsive insanity." His whole conduct for hours before the murder is marked by deliberation. He goes backwards and forwards from his house and evidently waits for the return of his wife. He visits the beer house, procures paper and coolly and collectedly writes the letter to the public which I have read to you. Epileptics do not behave in this fashion. They often betray homicidal tendencies, but it is just be-

fore or after a fit that they are liable to paroxysms of cerebral excitement, in which they may do violence to themselves or others. The testimony, however, as to Stone's being an epileptic was not all satisfactory. He may have had attacks in his youth, but there are many cases of lapsed or lost epilepsy—that is cases in which epileptic or epileptiform attacks have occurred once or oftener in life, and have not been repeated so as to interfere with the health or the duties of life—and this I am disposed to think was Stone's history. Even if he was insane at the time of committing the act, which I contend he was not, he was still responsible under the law. In order that insanity may be pleaded as a defense, it must be proved that the accused, however mad in other respects, was not conscious the act in itself was one he ought not to do, the act at the same time being contrary to the law of the land. Insane persons, unless they are idiots or suffering from epileptic unconsciousness, know the difference between right and wrong—know the law and that it is right to obey and wrong to disobey it. This is the legal view of the case. The medical scientific view is different. An accused person is not guilty of a crime actually committed if he is suffering from disease. Of course no one will doubt that insanity is a disease, but to prove the disease, you must prove the existence of the insanity. It is true that many alienists contend that there are types of insanity in which the ability to distinguish between right and wrong does not avail to protect its victim against maniacal impulse; that there is a moral insanity which impels to crime in spite of the clearest knowledge of its consequences. Was Stone's supposed insanity of this type? I insist it was not.

The London *Lancet*, commenting upon the connection between epilepsy and insanity, says, "an individual may be epileptic, and have fits, without being insane, or he may suffer from epileptic insanity with a scant history, or entire absence of known convulsive paroxysms. To what extent a man affected with epilepsy, which has not previously



produced mental disturbance, should be relieved from responsibility because the disease under which he labors *may*, and sometimes does, give rise to mind symptoms, is a moot question. It is, of course, permissible to contend that unless there is actual proof of insanity, its existence ought not to be inferred from the mere fact of a *possible* cause being in existence; just as no one would argue that a phthisical patient was irresponsible, because in certain cases there may be some mysterious relations between tubercular disease and mental derangement."

Now, this is the very contention that I make in this case. I contend that there was no actual proof of insanity furnished during Stone's trial, and that its existence ought not to be inferred from the fact that epilepsy was a family inheritance. To establish insanity you must establish irresponsibility. Irresponsibility is the inherent attribute of insanity. To prove a condition of irresponsibility scientific investigation is necessary, not coarse statements gleaned from ignorant and doubtful sources.

Of course, I know it would be an impossible thing to convict a man in our courts under the circumstances presented in the trial of Stone. A perfect stampede, a mental cyclone seizes jury, judge, populace, and even the counsel, often so imperturbable, are swept away by it—but it is nevertheless a stampede not a judgment. Has it come to this that every man or woman with a neurotic temperament and unstable mental character and bad family history is to be allowed to commit crime without restraint or punishment? This is certainly the ruling in this case.

If Stone was insane, Hazeltine, who was convicted about a year ago for the murder of a young woman, on North street, was doubly so. The son of a chronic inebriate,\* subject to epileptic attacks in his youth—always shy, wilful, moody and apparently unhappy—this boy, after a continuous and prolonged

debauch, bordering on delirium tremens, murders a girl in a manner similar to Stone's murder of his wife,—a girl with whom he has been intimate and who has given him no real cause of offence. The murder seems almost purposeless. Hazeltine, notwithstanding these facts, was not insane, and the jury rightly so determined. He knew right from wrong, and though badly constituted mentally, his impulses were the impulses of crime. He is now a useful, well behaved, and, it is to be hoped, a repentant convict.

It has, I think, been clearly shown that Stone was not suffering from an impulsive, fulminant form of epilepsy, and, therefore, to adjudge him innocent it must be shown that he was, and still is, the victim of a slow, progressive form of cerebral softening, due to an inherited trouble. Where, I ask, is the evidence of this progressive form of disease? The man was acquitted solely on his family history—particularly on the evidences of it offered the jury in the course of the trial.

I am aware that the distinguished alienist consulted by the State believed that Stone labored under a fixed, long cherished delusion which impelled him to commit the crime, and which by its force prevented the exercise of the ordinary powers of will;—in other words, that under the influence of this delusion he could not help committing the act, though he knew it to be wrong. I cannot see the proof of this delusion. The evidence shows that his mother-in-law was a perturbing element in his family life; that the conduct of his wife; her upbraidings and reproachings; her neglect of her duties, &c., were not a fanciful but a real grievance; that even the fears entertained as to the welfare of his daughters were well founded, though, perhaps, over-estimated by him. That these troubles may have generated a spirit of revenge, or, at least, may have brought about a determination on his part to rid himself of all worry, anxiety and sorrow by the murder of himself and wife, is, to my mind, a rational conclusion. Leaving the charge of his children to his friends and the community was the fitting result of a well

\*This fact was not brought out in the trial; but I do not think it would have greatly affected Dr. Gundry's or my own testimony in the case.

pondered and pre-determined act, the consequences of which he clearly foresaw. This theory seems to me to be the logical outcome of Stone's family life and of his mental peculiarities and temperament.

In England these cases are managed very differently. The man is adjudged guilty of the crime and the Home Government afterwards examines into the facts. The Commissioners in Lunacy, or other competent experts, examine the condemned prisoner. If he is insane he is committed to an asylum; if he is sane the penalty of the law is meted out to him. There is no such thing possible as an insane criminal roaming abroad in the community. The cases of Bradley, Patrick and Watson, already cited, show how differently and how much more wisely trials of this character are conducted in Great Britain. If Stone had been pronounced guilty by the jury, as he should have been, the Governor could have had a proper inquiry afterwards instituted by able and impartial men competent to decide the question of his sanity. It is a rare thing for an insane man to be executed in this country. Guiteau's case is an exceptional one, and will cause wonder and regret in days to come.

Unfortunately, a lay tribunal is not competent to decide questions of this character. Intelligent and unprejudiced medical testimony—that is testimony given by men trained in the investigation, and versed in the diagnosis of mind disorder and disease—is the only testimony that should be allowed to weigh in trials in which insanity is pleaded as a defense for crime. The sanity or insanity of a prisoner should be determined before he is placed on trial. In our own state the Commissioners in Lunacy would perhaps be the proper body to make the necessary inquiries and investigation. This would do away with the present plan of experts giving contradictory testimony in our courts much to the amusement of the laity and to the general discredit of the medical profession. In England the Home Government usually selects a well known general practitioner and an alienist of abil-

ity and experience to determine the mental condition of criminals supposed to be insane. The doctrine that a man may commit a crime under an insane impulse and the next moment become a rational and responsible being is a solemn outrage on the sense and patience of intelligent men, and yet this doctrine was asserted by an expert in our Criminal Court not two years ago.

It is to be hoped that a great and necessary reform may in this matter be speedily instituted in our own state, so that appropriate legal penalties may be wisely inflicted and that the vicious modes of trial at present in vogue may be forever discarded.

### Selected Articles.

#### ON THE NATURE OF SCROFULOUS GLANDS IN THE NECK AND THEIR SURGICAL\* TREATMENT.†

BY KENDAL FRANKS, F.R.C.S.I.,

Surgeon to the Adelaide Hospital, Dublin.

I should scarcely be justified in discussing the methods of dealing with that condition of the glands of the neck which centuries have agreed in calling *scrofulous*, were I not in the first place to attempt to explain what is meant in the present day by *scrofula*. According to the views which we hold on this subject will our treatment depend. If we look upon *scrofula* in all its stages as a *diathetic* disease, then our treatment will be directed to correct this tendency; in other words, we shall have recourse to constitutional measures as the most rational—as those which promise the greatest success. If we, on the other hand, hold that *scrofula* is *infective*, that it owes its origin to a virus making its way into the system from without, then our treatment should in the first place be directed against the virus, to keep it out of the system or to eliminate it. Between these two modes of estimating the

\*From the London *Lancet*, June 19th, 1886.

†Read before the surgical Section of the Academy of Medicine of Ireland, April 16th, 1886.



nature of the disease we have a third, which combines them both—namely, that scrofula is an infective disease due to a definite poison, which can only find its development, however, when planted in a suitable soil; that is to say, when it gains an entrance into the tissues of a person presenting a peculiar constitutional habit, “the greater vulnerability of parts and the greater pertinacity of this disturbances,” as Virchow has defined it.† If we accept this latter view and recent investigations, I believe, have fully established its truth—scrofula must cease to exist as a distinctive disease, and the neutral zone between scrofula and tubercle, which has been the battle-ground of pathologists in years past, must disappear. We shall never, I suppose, eliminate the term scrofulosis, but we shall use it in a different sense from that to which we have been accustomed. In the light of the pathology of to-day we cannot accept as a definition of scrofula that it is “a tendency in the individual to inflammations of a peculiar type, the distinctive features of such inflammations being as follows: they are usually chronic, apt to be induced by very slight irritation, and to persist after the irritation that induced them has disappeared.”§ In spite of the attempts of pathologists to give a definite meaning to the term, no one will deny that the word scrofula has been used to designate most of those diseases whose pathology was a chaos of confusion, and that Henle’s description of it was well merited, that “scrofula is the receptacle into which one vaguely casts all the ailments which afflict children under fourteen years, and of which we do not know the cause.”\* In discussing, then, the true nature of scrofula, it will be interesting to review shortly its history, and to trace the lines which have led to our present state of knowledge concerning it.

The term was originally given to the disease by the Romans in order “to give prominence to the similarity presented by the thickened neck, the diminished prominence of the chin, and the swelled

upper lip—all consequences of the swellings of the glands—with the physiognomy of the hog.”† In the sixteenth and seventeenth centuries the resemblance between the caseous masses found in the lungs in phthisis and in scrofulous lymphatic glands in the neck was observed, and Cullen amongst others, began to range phthisis in the list of scrofulous diseases. “The views generally held at that period on this question,” says Birch-Hirschfeld, “may be summed up in the sentence that scrofulosis reigned supreme over domain of tuberculosis, tubercular phthisis itself being looked upon as a scrofulous disease.” Laennec heralded a new epoch. Tubercle now became the chief factor, and all processes in which cheesy substance was found were classified with tuberculosis, scrofulous glands being considered only as a small subdivision of tubercular disease. But at this time little was known as to the nature of tubercle itself. The term was applied to nodules, but it had little other significance. Laennec pointed out that these nodules, originally grey and clear, had a tendency to become opaque and yellow, or, in other words, to caseate. Thus, in the lung two distinct conditions were found, the grey tubercle and the yellow, the latter being, however, the result of certain changes in the former—that is to say, the grey tubercle had a tendency to caseate in its centre, and by the fusion of several of these, larger caseous masses were formed, which went by the name of yellow tubercles. The identity of scrofulosis in the glands in the neck and of tuberculosis in the lung was then again called in question, when Virchow came forward and demonstrated that this cheesy substance was not necessarily due to decay of the grey nodules, but might occur in the most heterogeneous tissues. Tubercle was now restricted to grey semi-transparent nodules, the size of a millet-seed, hard and firm, which have since been known as miliary tubercles; although these, from their want of blood-vessels and their low organisation, frequently tended to cheesy metamor-

‡Krankhaften Geschwulste, Vorles. xxi.

§Treves: Scrofula and its Gland Diseases, p. 37. 1882.

\*Handbuch der Rationellen Pathologie. 1846-53.

†Birch-Hirschfeld, Ziemssen’s Cycloped., vol., xvi., p. 744.

phosis. Virchow accordingly laid down that no cheesy product was to be accepted as tuberculous unless sufficient evidence had been given of its origin from miliary tubercle. Such evidence was not at that time forthcoming in respect to the cheesy masses found in scrofulous glands; hence scrofulosis was not to be considered as a form of tuberculosis. Virchow went even further, and the cheesy infiltration of the lung, called "tuberculous" by Laennec, was not tubercular at all, but should be termed "scrofulous broncho-pneumonia." But even this position of the question was not destined to remain long unassailed. Microscopists turned their attention to the study of the so-called grey or miliary tubercle. That it was the ultimate specific cause of tuberculosis began to be doubted, as certain tissue changes, which were acknowledged to be due to tuberculosis, were found to occur sometimes, in which these distinct grey tubercles could not be discovered. In such instances the microscope revealed certain minute bodies, to which the name "submiliary tubercles" was given, and it was then shown that millet-seed bodies, termed miliary tubercles, were made up of a collection of these microscopic nodules. This submiliary tubercle, called by Köster "primitive or elementary tubercle," is composed mainly of cells. In the centre of a typical specimen we find one or more giant cells. Forming a zone around this are many so-called epithelioid cells, and around these again is a zone of leucocytes. "All these cell elements are supported by a fine reticulum, which is generally concentrically arranged at the periphery, and towards the centre is observed to be continuous with the processes that commonly come off from the giant cells. The affected district is non-vascular."\* This is the description of "primitive tubercle" as we understand it to-day; but it must not be supposed that this accurate histological account of it was received without much opposition. Indeed, it would seem that in its earlier days pathologists were so engaged

in their conflicts concerning it that the fight over the identity or non-identity of scrofulosis and tuberculosis remained for many years in the position in which it was left by Virchow. During this period of dormancy caseous or cheesy nodules were looked upon as the products of the degenerative changes which followed on scrofulous inflammation. There was nothing specific in them. But this controversy on scrofulosis was only dormant, and it broke out with renewed vigor in the years 1865-69. A new method of attacking the question was instigated by M. Villemin. Anatomical and microscopical methods gave way to the method of inoculation, and Virchow's ground was cut from beneath his feet. These inoculation experiments showed two things, firstly, that if the cheesy matter from scrofulous glands were injected into an animal, it produced general tuberculosis as readily as tuberculous matter; and secondly, as shown by Wilson Fox, that if tuberculous matter were introduced beneath the skin, it gave rise to enlarged caseous and suppurating glands—in fact, to all the symptoms of a localised scrofula. The conclusion to be drawn from these experiments seems obvious—namely, that these local manifestations of what was termed scrofula were in reality tubercular, and that if any difference could be made out between these terms, it could only be one of degree. Such a wholesale subversion of Virchow's views, which had taken possession of pathologists for several years, could not naturally be accepted without dispute. The experiments themselves were largely discounted, and it was maintained that, as the so-called acute general tuberculosis, which was described as following on inoculation, occurred in "animals," it was not the same as general tuberculosis in man. It now became apparent that it was more necessary than ever to understand the histological characters of true tubercle, to distinguish it from simple inflammatory neoplasms, and to determine whether the giant cell, with its external zones of epithelioid cells and leucocytes, was pathognomonic of tubercular diseases. In 1870 Wagner prepared the

\*Treves, op. cit., p. 9.



ground for a more accurate knowledge of the microscopical characters of these primitive tubercles, and the more complete elucidation of their differences from simple inflammatory neoplasms, made almost immediately afterwards by Schüppel, established their distinctive character. With this definite idea as to the true characteristics of tubercle itself, he proceeded to combat Virchow's views, taking for his text Virchow's own dictum that no cheesy product was to be accepted as tuberculous unless sufficient evidence had been given of its origin from miliary tubercle. This missing link was now supplied. "This demonstration," says Birch-Hirschfeld, "has been furnished by Schüppel's numerous and searching investigations to such an extent that no further doubt is left as to the frequent occurrence of well-characterised tubercle in the lymphatic glands, partly in the form of secondary development with pre-existing tubercles of other organs; partly, however, as primary tuberculosis, to which latter category belong those very conditions which have been regarded heretofore as the most characteristic products of scrofulous disease.\* Friedländer goes a step further when he states that "all the more important scrofulous affections are intimately associated with the formation of tubercles."† From this period the number of diseases in which tubercle was discovered went on increasing year by year. Köster in 1869 found them in the so-called granulations in "white swelling." In 1879 Volkmann demonstrated that "white swellings" were nothing but tubercular osteo-arthritis, and that they owed their origin most frequently to a focus of tubercle in the epiphysis. In 1881 Lannelongue showed in his work on cold abscesses that the walls of the sac were studded with tubercles; and in 1883 Kiener demonstrated the identity between caries and tubercular osteitis, and showed that this specific osteitis may assume either the encysted or diffused form. The advocates of the identity between scrofula and tuberculosis seems thus to

be triumphing along the whole line, when a new difficulty arose. The giant cell, with its peculiar arrangement of cells around it, was declared not to be pathognomonic of tuberculosis. In 1875 Ziegler showed that it was found in inflammation artificially produced by inserting two little glass discs beneath the skin or in some of the cavities of the body in dogs and rabbits, and M. Martin obtained them around other irritating particles, or by introducing microorganisms into the circulation. The question was thus again an open one, and stood thus: inoculation experiments had crowned the proof, afforded by anatomical and clinical observations, that scrofulosis and tuberculosis could not be separated, but hitherto there was no peculiarity of the structure which was pathognomonic of tubercle as a specific element. The infective nature of tuberculous and scrofulous matter alike was established, but the *materies morbi*, the virus itself, had not been recognized. Such, briefly, may be said to have been the point reached up to the spring of 1882. We all remember the sensation which was caused, not only among scientists, but in the world at large, by the announcement of Koch in March of that year, that he had discovered the bacillus of tubercle; that he had succeeded by the method of double staining with aniline dyes in demonstrating the existence of the microbe; that by cultivations on solid media he had isolated it; and that by inoculations of the pure cultivations in animals he had proved its virulence. Whatever doubts may have been at first thrown upon the discovery, whatever scepticism may have been at work to detract from it or to prove it false, all have disappeared, and there are few who to-day will deny that Koch's bacillus is the active agent in the production of tubercular diseases, wherever they are found or in whatever guise they appear. Virchow's statement that no cheesy product was to be accepted as tuberculous unless sufficient evidence had been given of its origin from miliary tubercle must now be modified and enlarged. In place of it we may assert that all inflammatory products, whether in the stage of cheesy

\*Op. cit., p. 751.

†Volkmann's Samml. Klin. Vorträge, No. 64.

degeneration or not, in which the bacillus of tubercle can be demonstrated, are to be accepted as tuberculous. At the same time we must remember that their absence is not conclusive evidence against the tuberculous nature of a diseased part, as in certain stages of a tuberculous mass the bacilli may disappear. What assistance this discovery has afforded to the physician, or what influence it has had upon his art, is not my object to discuss. For the surgeon it has opened up new fields of labor, and has had a most powerful influence on his work. "The sphere of tubercular diseases," writes Volkmann recently,\* "with which the surgeon has to do has increased so enormously during the last fifteen years, inasmuch as a great number of diseases with which he has to deal day by day are recognized to belong to tuberculosis, that, I say, the surgeon has now almost more to do with this disease than the physician."

Addressing as I am the surgical section of this Academy, let me call your attention to the enormous advantage which the surgeon possesses over the physician in the treatment of tubercular diseases. The diseased tissues are, or can be, exposed to view; frequently it is in the surgeon's power to remove the whole tuberculous patch, and with it the tissues in the immediate neighborhood, while the patient still lives, and his opportunities for doing so, and the organs that are accessible to him, are increasing year by year. Now, in order to establish a disease in any organ as being undoubtedly tubercular, Volkmann† enumerates three conditions as coexisting. Firstly, the well-known structural condition, which has been styled "true tubercle;" secondly, the presence of the tubercle bacillus; and, thirdly, the positive results yielded by inoculation experiments. When these three conditions are verified in any diseased part, it cannot be questioned that the affection is one of true tuberculosis. This criterion has been applied to a large number of diseases, and has given positive results. I

cannot now do more than enumerate a few of those diseases with which we are familiar under other names, but which henceforth must be classed as tubercular. On the skin we find lupus and certain ulcers, which have commonly been classed as scrofulous; similar conditions of the mucous membranes, and frequently fistula in ano; in the deeper structures, most forms of chronic abscesses, especially those associated with scrofulous glands, diseased bone, &c.; and in diagnosing these abscesses the so-called pyogenic membrane is of great use. "The characteristic abscess membrane," says Volkmann, "occurs only in connection with tubercular abscesses, and it must be looked upon therefore as an absolutely safe criterion for diagnosis." All those forms of disease of the bones and joints which have hitherto been described as caries, Pott's caries, white swelling, strumous or scrofulous disease of the joints, fungous degeneration and so forth, belong also undoubtedly to tubercular infection, and the same is true whether the disease originate in the epiphyses of the bones or in the synovial membrane. Lastly, of all parts of the body in which positive proof of the existence of tubercle has been given, the lymphatic glands are most frequently engaged, because their very function exposes them to infection. Under the head of tubercle we must range all those affections of the glands which have hitherto been termed scrofulous enlargement, strumous disease, and caseous degeneration—in fact, by far the larger number of cases in which we find the glands of the neck enlarged.

(To be continued.)

### Correspondence.

#### AQUA ACIDI CARBONICI.

BALTIMORE, July 14th, 1886.

*Editor Maryland Medical Journal.*

SIR:—A few weeks ago I wrote the following prescription, which was taken to a respectable drug store.

\*Langenbeck's Archiv für Klin. Chirurg., 1886, p. 109.

†Op. cit., p. 125.



R. Salis Rochelle ʒss.  
 Syr. Limonis  
 Syr. Zingiberis āā ʒi.  
 Aquæ Acidi Carbonici ʒj.

Misce.

Upon visiting my patient, a lady, on the following day, much to my surprise, she complained of the disagreeableness of the medicine. I found her also suffering from some unpleasant head symptoms, for which I could find no explanation. I found upon inquiry at the drug store that the clerk on duty had put up five ounce of *carbolic acid water* in place of the simple menstrum I had ordered. The prescription was written very plainly and no possible explanation of the blunder could be given.

On the fourth of July I wrote the same prescription for another patient, with the addition of two scruples of the bromide of sodium, ordering the mixture to be taken at a draught. This prescription was taken to the store of Mr. Adam J. Gosman. The clerk on duty refused to put it up, stating that it would endanger the life of the patient. He suggested that the prescription should be taken to Mr. Jennings' pharmacy. Mr. Jennings' clerk also refused to prepare it, giving as a reason that five ounces of carbolic acid water was a dangerous dose. My patient then came to me in great alarm with the prescription. I sent it back without the least alteration to Mr. Gosman, telling the lady who had it to give my compliments to the clerk, and say to him that aqua acidi carbonici meant "soda water" or "mineral water," or, in other words the water that he furnishes daily to citizens from the fountain. The prescription was then filled, and, as a consequence, my patient's mind and bowels were both greatly relieved.

Is it possible, Mr. Editor, that drug clerks do not as a rule know the difference between carbolic acid and carbonic acid water? My experience in the cases above cited would seem to give color to this opinion. It is not a pleasant thing for a medical man to have his prescription returned to him on the ground that it is dangerous, when it is the simplest remedy possible and is written in the

plainest manner. I thus publicly call attention to this matter, so that future mistakes may be averted.

Very faithfully yours,

JOHN MORRIS, M.D.

SPARTEINE AT HOME.—Dr. Thomas H. Buckler, of Clifton, Md., writes to the *Boston Med. and Surg. Jour.*: The expensive Sparteine lately recommended by Germain Sée for cardiac weakness, is prepared from Scotch broom,—*spartium scoparium*,—the *Planta Genista* or emblem of the Plantagenets, which grows in many parts of the thirteen original States, on sterile soil. It was brought over here by the Scotch and English to prevent the washing of gravelly roads and gutters. It should be cut and gathered at this season and dried like hay. Its active principle is extremely soluble in water, and two ounces of ground or contused stems to a quart of boiling water, a wine-glassful for a dose, every eight hours, is equivalent to a grain and a half of the prepared gum used by Dr. Sée. This remedy is useful not only in failure of the cardiac ganglia but as a tonic to the organic and vaso-motor nerves in whatever part of the body congestions occur from loss of power in them. I have used this agent in the form of infusion for half a century and with marked advantage in many cases.

HOW TO DETECT ACETONE IN URINE.—It is stated by Mons. P. Chautard that the presence of acetone in urine or pathological liquids may be readily detected by adding a drop of an aqueous solution of magenta decolorized by sulphurous acid to the suspected liquid, when, if acetone is present, a violet color is produced, the intensity of which is proportional to the amount present. In dilute solutions the coloration does not appear until after four or five minutes; if the amount of acetone is very minute, the urine or other liquid may be distilled, the first portion that comes over being examined. In this way a very minute proportion of acetone may be detected. —*Lancet*, May 15, 1886.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, JULY 17, 1886.

**Editorial.**

THE EARLY DIAGNOSIS OF CANCER OF CERVIX UTERI.—This subject has recently been discussed in a very careful paper read before the Cincinnati Academy of Medicine (*Medical News*, July 10th, 1886) by Dr. C. B. Palmer, of that city. Dr. Palmer claims on good authority that cancer is three times more frequent in women than in men, and that one-third to one-half the total number of cases in women involve the uterus. The fact cannot be disputed, we think, that uterine cancer is far more common than formerly and is occurring with increasing frequency. The cause for this is assigned by Dr. Palmer to the growing changes in the habits of living among modern people, cancer being a disease which follows in the wake of civilization. Lacerations of the cervix uteri are assigned as the most potent causes of cancer by Emmet and other writers, and as lacerations are believed to occur more frequently now than in former times, an easy explanation for the growing frequency of cancer is at hand.

Dr. Palmer accepts the growing opinion that uterine cancer is primarily a local disease and that the system is implicated secondarily. Holding this opinion the early recognition of the disease is considered of vast importance, since upon a correct diagnosis hinges the correct method of treatment.

If the disease be purely local the sooner it is radically removed the better

for the subsequent welfare of the patient. It is well-known that when the disease is once fully established and has extended to surrounding parts, entire extirpation is impracticable.

The diseases of a malignant type which affect the uterus are carcinoma, epithelioma, and sarcoma. The two first usually begin in the cervix, whilst sarcoma with the same uniformity involves the body. The origin of cancer in the body must be extremely rare since Schroeder estimates it at less than two per cent.

The benign affections of the cervix most likely to be confounded with the malignant, are classed by Dr. Palmer as a diffuse interstitial cervical metritis; a condition commencing with hyperæmia verging into hyperplasia, leaving the structures enlarged, irregular, and indurated. Associated with these conditions and very often independent of them are found endometrial inflammation with its results, erosions, granular and cystic degenerations, ectropion, the surface being the seat of various discharges of mucus, pus or blood. Syphilitic ulceration and the like may be mistaken for malignant disease. Ordinarily the recognition of the benign affections is easy enough to the experienced clinical observer, and malignant diseases of the cervix in their advanced form are so pronounced as to scarcely escape detection, still mistakes are constantly occurring, especially when the benign and malignant affections so nearly resemble each other as to make the diagnosis purely speculative. The very moment when a disease ceases to be benign and commences to take on malignant action, will probably not be determined by any microscopical or clinical test now known. But this fact does not do away with the great importance of an effort to recognize a malignant disease of any early type.

Dr. Palmer discusses this subject from two standpoints: 1. The form of cancer simulating or confounded with parenchymatous or fibrous benign diseases of the cervix. 2. The form of cancer mistaken for, simulating, or simulated by, endometrial diseases.



Exactly what anatomical structure which, in point of origin, undergoes the primary change of cancer he considers uncertain. "Probably the origin of carcinoma begins in a degeneration of the connective tissue cells, either under the mucous membrane of the vaginal face of the cervix or up within the cervical canal, while the epithelial growths or ulcerations first invade the superficial epithelium."

"A carcinomatous infiltration arising within the connective tissue cells of the cervix, at once heightens the vascularity of the part, which in color looks reddish or bluish, produces nodulations more or less hard, and reduces the mobility of the superjacent mucous membrane. \* \* \* Should these changes of a commencing malignancy start in the cervix previously healthy, or so little diseased as to excite no special attention, they progress so insidiously—it may be slowly—that in all probability the patient will not call upon her physician until the second or ulcerative stage has advanced. Or should they commence in a cervix already diseased by chronic inflammation, one that is being inspected for treatment from time to time, they may even advance to a considerable degree before any special suspicion is excited." The question now arises, Can a diagnosis be made of the disease in its exact nature? In most instances Dr. Palmer thinks it can. In incipient malignancy he thinks the redness arising from local congestion is more intense; if the epithelium be lost, the papillæ below are more prominent, and these bleed more easily upon touch; the circumscribed induration is more marked.

But the most accurate test of malignancy suggested by Dr. Palmer is expressed in the sentence, "But much valuable information can be gathered by carefully watching the developments of treatment." In other words if all the local conditions, leucorrhœa, erosion, induration, etc., do not improve under well directed local treatment, but only slightly—never permanently—change for the better, we may regard the condition as malignant. The ten-

dency of malignant disease is to progressively get worse. Having this history before us the suspicion of malignancy should never be dismissed from our minds and the progress of the disease should be closely watched for the very earliest opportunity for interference. If any doubt remains the suggestion made by Dr. Palmer, to excise a small section of indurated tissue for microscopical examination, is a good one.

Under the second heading Dr. Palmer considers the form of cancer mistaken for, simulating, or simulated by, endometrial disease. Errors of diagnosis are not as easily made in recognizing epithelioma as carcinoma. The origin of epithelial growths of the cervix is traced to lacerations occurring during parturition. In bilateral tears of the cervix the walls gape and, sooner or later, a progressive hyperplasia, papillary and follicular increases the size of the cervix, creates erosion of the separated lips, which become covered with a mass of fungoid granulations. At first these granulations remain innocent, but they may quickly develop into malignancy. The frequency and rapidity of their degeneration are determined by constitutional states. The fact that epithelial cancer is exceedingly rare in virgins, or women who have never been pregnant, is advanced as an argument in support of the origin of epithelioma in cervical laceration in which the torn surfaces never cicatrize. Cicatrization, whether by nature or art is never a complete barrier. Cicatrization, Dr. Palmer claims, does not do away with the ill consequences of laceration such as eversion, hyperplasia and follicular degeneration; from the deep layers of the squamous epithelium of the everted surfaces, or from the greatly increased glandular epithelium a cancerous growth may spring up.

It is extremely difficult, if not impossible, to determine the exact nature of an endometrial growth in the edges of a lacerated cervix. We have more than once seen masses of vegetating fungosities springing from the everted lips of the torn cervix uteri, presenting every appearance of malignancy, which disap-

peared so rapidly under local treatment as to leave no doubt as to their benign character. In point of fact the results of local treatment were the only confirmatory evidences of non-malignancy. Whenever these endometrial growths occur in the cervix their prompt removal, either with scissors, curette or caustic agents is clearly indicated. It will often happen that the local disease is immensely improved by the treatment instituted, especially if this treatment includes a repair of the lesions of childbirth. This will especially be the case if the local trouble is inflammatory and benign. Even grant that the cancerous degeneration is fixed in some of these cases we may still hope to arrest the progress of the degenerative changes by prompt removal of all apparently diseased tissues. It is well known that epithelioma of the cervix uteri is the least malignant of all malignant growths. The disease may remain localized for years. Prompt removal therefore promises the very best results.

We quite endorse the closing words of Dr. Palmer's paper. "And not only ought extirpation to be early and thorough in epithelioma, but the causes giving rise to, and the conditions simulating and degenerating into the same, should receive proper surgical attention. Whilst the outlook is less favorable for a carcinoma proper, the same principles hold good. Suspicious cases should be subjected to the most rigid scrutiny, all diagnostic tests being applied. Doubts may still remain. But truly doubtful cases should come under the same class demanding operative treatment. If now and then one is subjected to treatment not absolutely needed, a greater number will obtain a measure of relief, a prolongation of life, and easier death."

**TREATMENT OF PENETRATING WOUNDS OF THE CRANIUM, WITH LODGMENT OF A FOREIGN BODY IN THE BRAIN.**—In our issue of June 3rd we presented some remarks upon a case of pistol wound of the cranium, with lodgment of the bullet in the brain; we desire at this time to consider briefly the indications for treatment in such conditions, viewed in the

light of modern surgery. We have already stated that the case mentioned in our editorial was remarkable but not unique. Ten years ago Dr. H. R. Wharton, in an inaugural thesis, collected 308 cases of foreign bodies of various kinds lodged in the brain, (Agnew's Surgery, Vol. I, p. 294) of which 141 recovered and 167 terminated fatally. In 104 cases the foreign body was removed, and of these 68 recovered and 36 died, whilst of 204 in which the foreign body was not removed 73 cases recovered and 131 died. We see from these figures the very great importance of extracting all foreign bodies which have gained an entrance into the cranial cavity, as in the first instance 65½ per cent. recovered, whilst in the second the percentage of recoveries is only 35½. More akin to the subject under consideration is the result of the gun-shot injuries of the brain. Of the cases mentioned about 272 were the result of gun-shot wounds. From 86 of these the bullet was extracted, with 54 recoveries and 32 deaths. Of the 186 in which the body was not removed, only 70 recovered and 116 died. Here we see again the very great differences in the proportion of recoveries in the two cases, the mortality in the first being only 37½ per cent., in the second it reaches 62½ per cent. It must be remembered, however, that the term recovery in these cases is simply a relative one, meaning that the patient did not die from the immediate effects of the injury, but many of them suffered subsequently from more or less remote effects, such as vertigo, mental disturbance and epilepsy. With these statistics borne in mind it becomes us to consider carefully what to do when a case of penetrating cranial wound is presented for our treatment. If there is doubt whether the ball has entered the cranial cavity, we consider it improper to be too inquisitive; the patient will stand a better chance for life if he is let alone, or placed upon an antiphlogistic treatment, and the wound treated antiseptically, but when the vault of the cranium has been penetrated and the brain has been manifestly injured the case is different. The patient will require as much anti-



phlogistic or sedative and antiseptic treatment as in the case in which there is doubt, but the ball and other foreign bodies ought to be extracted if it can be done without too much injury to the cerebral tissue. As in these cases the internal table is liable to be more extensively shattered than the outer, it may be proper to apply the trephine in order to remove any offending spiculæ of bone. Having exposed the seat of injury, a Nelaton's or other large probe may be gently passed along the shot wound in order to localise the body. If this can be found at a moderate depth it may be extracted by suitable forceps which have been rendered antiseptic. In some cases it is evident that the ball has transversed the entire thickness of the cerebral hemispheres and has infringed upon the opposite wall of the cranium. Several cases have been reported in which a counter opening has been made on the opposite side of the head, and the foreign body discovered and removed. Perhaps the most remarkable case of extraction of a bullet from the brain was that of Dr. W. F. Fluhrer, of N. Y., in 1884. A man shot himself in the centre of the forehead, producing paralysis of motion on the right side below the head. Under bichloride irrigation a bulb pointed probe was introduced and the point noted at which the probe would emerge if projected through the head. At this point the trephine was applied and the opening enlarged with the rongeur, the dura mater incised and contused brain substance and a rent in the pia mater showed the proximity of the foreign body, which was exactly localised with a probe and easily extracted with slender forceps. A tube was passed entirely through the head ensuring free drainage, and the patient recovered and returned to his former occupation. There are also some portions of the base of the cranium which are accessible both for the entrance of foreign bodies and for their extraction, notably the anterior fossa. Upon several occasions fragments of guns have entered the orbit and lodged in the brain, as the result of explosions, and have been removed by the same channel.

Our own views, then, in regard to the

treatment of these cases of penetration of the brain, with lodgment of the foreign body, is as follows: If it is evident that the brain has been penetrated and the missile retained, the wound should be explored under rigid antiseptic precautions, and if the foreign body can be accurately located, cautious attempts should be made to extract it. After removal of the body, the track should be carefully drained and treated antiseptically. If the missile cannot be localised without much penetration of brain tissue it had best be let alone, in hope that it may become encysted and give no further trouble. When the ball passes through the brain from one side to the other, as proven by the careful use of the probe, a counter opening should be made with the trephine and rongeur, and the body extracted through this opening. It is of the utmost importance in these cases that the treatment should be rigidly antiseptic, and that thorough drainage should be secured.

### Miscellany.

EFFECT OF BITTERS ON DIGESTION.—Dr. Cheltsoff, chief of Professor Botkin's clinic, thinks that extracts of the so-called "pure bitters," which are usually prescribed with the view of stimulating the secretion of gastric juice and of aiding digestion, so far from having any beneficial effect of that kind, are absolutely injurious, inasmuch as they retard the digestive functions. He has made a series of experiments with extracts of aurantium, gentian, trifolium, absinthium, calumba, cascarrilla, and quassia on (1) gastric digestion, and the secretion of gastric juice; (2) pancreatic digestion, and the secretion of pancreatic juice; (3) the secretion of bile; (4) fermentation; and (5) nitrogenous metamorphosis. The conclusions at which he arrived were that bitter extracts, even in small doses, interfere with artificial gastric digestion, and also with the gastric digestion of animals, but not to so great an extent. Large doses of bitter extracts diminish the secretion of gastric juice, though small doses effect a slight and transitory increase of it, the diges-

tive power of the fluid being, however, in all cases diminished. Bitter extracts have no effect on the secretion of pancreatic fluid, but they nevertheless retard hypogastric digestion. The action of bitter extracts on the secretion of bile is various; extract of absinthium, extract of trifolium, and large doses of extract of cetrarin, slightly increase it, usually at least, but not invariably; while extract of quassia, extract of calumba, and small doses of extract of cetrarin, have no effect at all. Bitter extracts have no anti-fermentative effect, and do not hinder suppuration. Lastly, assimilation of nitrogenous substance is diminished by the use of these extracts. —*Lancet*, May 15, 1886.

EXPLOSIVE COMPOUNDS.—Vigier (*Gaz hebdom. de méd. et de chir.*, May 21, 1886) calls attention to some interesting observations by Duchesne on dangerous pharmaceutical preparations. The following are mentioned as the most common:

1. A tooth-powder containing cachou and chlorate of potassium.
  2. A pill containing permanganate of potassium and reduced iron.
  3. A gargle of chlorate of potassium, perchloride of iron, and glycerin.
  4. A mixture of hypophosphite of calcium, chlorate of potassium, and lactate of iron.
  5. A mixture of hypophosphite of calcium, chlorate of potassium, and distilled water.
  6. A mixture of chromic acid and glycerin.
  7. A powder of chlorate of potassium, tannin, and hydrochlorate of morphine.
- N. Y. Med. Journal*.

MAGENDIE'S SOLUTION IN POST-PARTUM HÆMORRHAGE.—M. S. McMahan, M.D., of Oakland, Cal., writes to the *N. Y. Medical Journal*: I find in the journal for June 12th a letter from Dr. Thomas G. Duncan, on post-partum hæmorrhage, which reminds me of the fact that I have had little trouble with those usually troublesome and often dangerous cases since adopting the following plan of treatment, and which I have invariably followed for more than fifteen years: On

finding the surface of the patient pale, the extremities cold, with profuse hæmorrhage, I at once inject hypodermically from ten to fifteen minims of Magendie's solution of sulphate of morphine. This will invariably, and within a few minutes, produce a flushed surface, warm the extremities, and a stopped or much diminished flow. I adopt no other means—no styptics, no compresses, and no foolish "plugging."

A LOTION FOR PITYRIASIS CAPITIS.—VIGIER (*Gaz. Hebdom. de Med. et de Chir.*, April 2, 1886) recommends the lotion for pityriasis of the scalp and to arrest incipient baldness:

Alcohol, - - - - -	3 ounces.
Spirit of camphor,	} each 75 grains.
Rum,	
Tincture of cantharides,	
Glycerine,	
Essence of sandal-wood,	} each 5 drops.
Essence of wintergreen,	
Essence of roses,	
Essence of laurel,	
Hydrochlorate of pilocarpine,	7½ grains.

Dissolve the pilocarpine in the alcohol, and add the other ingredients. To be lightly rubbed on the scalp once a day. —*N. Y. Med. Jour.*, May 1, 1886.

THE SURGERY OF THE PANCREAS.—Dr. Nicholis Senn, of Milwaukee, publishes in the July number of *The American Journal of the Medical Sciences*, an elaborate paper, based upon experiments and clinical researches, in which he attempts to lay the foundations for a rational method of treatment of some of the injuries and diseases of the pancreas by direct surgical measures. The literature on the surgery of the pancreas is exceedingly scanty and loosely scattered through the medical journals and textbooks, as no previous attempt has been made to arrange the material in a systematic form for ready reference. Our present knowledge of the surgical treatment of diseases of the pancreas, is limited to a few operations performed for the cure of retention cysts, by excision or the formation of an external pancreatic fistula. The clinical material



which he has collected, and more particularly the description of pathological conditions found within and around the pancreas at post-mortem examinations, is utilized for the purpose of pointing out new indications for operative interference, by such methods as will suggest themselves from the results obtained by experiments upon animals.

LOCAL APPLICATIONS FOR USE IN NEURALGIAS.—The *Revue de Thérapeutique* for May 15, 1886, gives the following formulæ:

Intercostal neuralgia may be greatly relieved by daily gentle inunctions with a portion, of about the bulk of a pea, of a pomade thus constituted:

Morphine chloride,	
Veratrine, - - - -	gr. iss.
Cold cream, - - - -	Div.

In lumbago or painful contraction of the muscles of the back a liniment containing one part of tincture of capsicum in six parts of olive oil, is advantageously applicable. If its infriktion be painful, it may be applied on flannel.—*Med. News.*

THE FUNCTIONS OF THE MEMBRANA TYMPANI ILLUSTRATED BY DISEASE.—Sir Wm. Dalby, in a brief but instructive article in the July issue of *The American Journal of the Medical Sciences*, points out that our knowledge of the functions of the membrana tympani may be added to by the observation of this structure when it becomes altered by disease. He points out that structural changes in the tympanic membrane, as, for instance, extensive calcareous deposits of a very extensive nature may exist without impairment of hearing. The history of cases in which there have been such deposits with diminution of hearing shows that the patients have at some previous period suffered from inflammation within the tympanic cavity, so that the changes then wrought will sufficiently account for the failure in hearing. That the position of the obstacle to hearing is in the conducting media, and, therefore, in the tympanic cavity, and not in the nervous structure can be

in such cases readily demonstrated by experiments with the tuning-fork.

Loss of continuity in the tympanic membrane, he also shows, does not necessarily interfere with its function, provided that the ligamentous support which it affords to the chain of ossicles is not impaired.

In several instances in which the membrane has been accidently pierced with a very sharp-pointed object, as a pin, the hearing has not been found, with the most careful tests, to be injured. In these examples the healing process occupied from three to four days.

In one case, when a sudden explosion near the ear ruptured the membrane in two places, the hearing was perfect, and the ruptures healed in a few days. On comparing the notes of other cases in which the hearing was impaired by explosions, it was found that the hearing suffered more injury when the membrane was not ruptured than when it was. It would almost seem from this that the force of the explosion expended itself partially in rupturing the membrane, and so, in a measure, some hearing was saved. At any rate, it appears not an unfair conclusion that the loss of hearing must be due, in all cases, to damage to the nervous structures; in other words, to what, for want of a more accurate term, must be called shock.

That loss of continuity in the tympanic membrane does not of itself interfere with its functions is still further shown by the careful and continual observation of cases in which the membrane is perforated by incision or by disease, and the author thinks that the loss of hearing is due to causes which do not include this loss of continuity in the tympanic membrane.

TWO NEW BURSÆ AT THE KNEE-JOINT.—M. Poirier demonstrated, at a recent session of the Paris Anatomical Society, the existence of two new serous bursæ at the knee. They are situated, the one between the internal lateral ligament and the femur, the other between this same ligament and the tibia, and are separated from each other by the insertion of the internal ligament into the

inter-articular cartilage. There is generally considered to be a prolongation of the articular synovial membrane at this point.—*Lancet*, June 19, 1886.

**INDIAN HEMP IN DENTAL OPERATIONS.**—Indian hemp is recommended by Dr. Aarousin as an anæsthetic during dental operations. The tincture is diluted with from three to five times its volume, and applied by means of a plug of cotton-wool to the cavity of the tooth, and, in addition, is painted on the gum in the neighborhood of the diseased tooth with a brush. The top of the tooth, too, may be similarly treated.—*Lancet*, June 19, 1886.

**A SIGN OF DEATH.**—M. Lessenne, at a meeting of the Société Médicale d'Amiens, pointed out the following simple and trustworthy sign of death. After pricking the skin with a needle the puncture remains open, just as when a piece of leather is pricked. On the living body, even if the blood does not come to the surface, as would happen if the person were hysterical, the pin-prick closes at once, and does not leave the slightest trace.—*Med. News*.

**IODOFORM AND NITRATE OF SILVER AS A CAUSTIC.**—Malthe ("Jour. de méd.," "Med. Chronicle," June, 1886) recommends a combination of these substances for application to chronic ulcers. He first sprinkles the surface of the ulcer with iodoform, and then applies the stick of nitrate of silver, afterward sprinkling on more iodoform. Chemical reaction evolves nitrous and nitric acids, iodine, and iodide of silver, which, in their nascent state, stimulate the tissue to healthy action.—*N. Y. Med. Jour*.

**THE FUNCTION OF THE RECURRENT LARYNGEAL NERVE.**—The mode of action of the recurrent laryngeal nerve, supplying as it does muscles so important in their use, both phonatory and respiratory, and yet so opposed in their action, is a much mooted point upon which Dr. Frank Donaldson, Jr., of this city, endeavors to throw additional light, in an experimental paper in the July num-

ber of *The American Journal of the Medical Sciences*. The recurrent laryngeal supplies all the intrinsic muscles of the larynx with the exception of the crico-thyroid, and it is chiefly a motor nerve. It is a physiological fact, also, that the internal thyro-arytenoids, the lateral crico-arytenoids, and the transverse arytenoids, are the adductor (the phonatory) muscles of the larynx, and that the posterior crico-arytenoids are the abductor (the respiratory) muscles of that organ, and all these muscles receive their nerve supply from the recurrent laryngeal. This nerve, then, must contain two sets of fibres, which innervate muscles of separate and distinct functions. How, and under what circumstances, does the constrictor or respiratory function of this nerve assert itself, is the important question to be answered.

As the result of his experimentation and study Dr. Donaldson explains the innervation of the larynx somewhat as follows: Breathing is an involuntary act, though the diaphragm and all the other muscles employed in respiration are voluntary muscles; and though respiration may be modified within very wide limits by the will, yet we habitually breathe without the intervention of the will. The larynx is an essential part of the respiratory apparatus and is immediately connected with, and must receive impulses from, the respiratory centre in the medulla, and its respiratory function is the most important; for the purpose of preserving life the glottis must be kept open, and so we find that the cords, even in normal breathing, at each inspiration are pulled slightly away from their apparently normal position between extreme abduction and extreme adduction. The fact that in deep narcosis the cords are pulled widely apart, would seem to show that stronger stimuli than usual are proceeding from the respiratory centre to the abductor muscles; for in all deep narcosis the tendency is toward dyspnoea, and always in this condition normal respiratory muscles are called into greater play. The constrictors of the larynx are apparently always in a state of partial tonic contraction, and ready for use at any moment, and the respira-



tory function of the larynx being for the moment in abeyance, the protective or constrictor function of that organ asserts itself. Again, it is well known that great changes can be brought about in the respiratory movements by the will; while, on the other hand, the respiratory centre is the one most frequently affected by nervous impulses from various quarters. He thinks that his experiments support the supposition that both the respiratory and constrictor (or protective) functions of the glottis are governed by those laws which govern the rest of the respiratory apparatus. The larynx, being part of the general respiratory apparatus, its inspiratory and expiratory (constricting) functions are under the same nerve control as the rest of the organs concerned in inspiration, and under no circumstances are these functions suspended.

There seems to be a similarity between the nerve fibres of the recurrent and those of the pneumogastric; the two sets of fibres of the recurrent supply opposite sets of muscles, and may be likened to the two kinds of nerve fibres composing the pneumogastric—the one answering to less, the other to stronger stimuli.

**RIVA ON THE DIRECT TREATMENT OF PULMONARY TUBERCULOSIS.**—Phthisis being now generally held to be due to a special parasite, whose site of predilection is the lung, antiparasitic treatment naturally suggests itself. Owing to the great resistance of the tubercular germ, inhalations have proved inefficacious. Surgical treatment so far has not given good results, and it is not generally applicable. Professor Riva, in a paper read before the Italian Medical Association, thinks that injections into the pulmonary parenchyma offer the most chances of success. The injections should be made with a Pravaz's syringe, in an intercostal space in the axillary or the posterior region. He notes the slight effects of the injections, which cause no pain, and rarely cough, if a bronchus be injured. He has seen the evening temperature lowered. He uses turpentine, creasote with alcohol (1 to 10), water being added until the mixture becomes clouded, bichloride of mercury

(0.5 to 1,000), carbolic acid, etc.—*Gaz. Med. Ital.-Lombard—Lond. Med. Record*, May 15, 1886.

**CHOLERA IN SPAIN IN 1885.**—From an official statistical report on the cholera epidemic in Spain in 1885 recently issued in Madrid, an abstract of which is published in *The Lancet* (June 26, 1886) it appears that the cases reported in the entire kingdom were 338,685, of which 119,620, or more than 35 per cent. proved fatal. This mortality was equal to a rate of 70 per 1,000 of the population, which is more than double the rate from the same cause in England and Wales during the epidemic of 1849, which was 30 per 1,000.

The cholera epidemic was confined to less than one-half of the population, so that in reality the actual death-rate from the disease in the portion of the kingdom actually invaded by the epidemic was equal to 182 per 1,000 of the population.

The first case of the disease made its appearance in the province of Valencia, in February, 1885, and by the close of the year the epidemic had virtually expended itself, only a few cases being reported towards the end of March last in the province of Cadiz.

As the average annual mortality in American cities ranges from 17 to 28 per 1,000 population, some idea may be obtained of a scourge which removed 182 individuals out of every 1,000 of population in the same period of time.

**ERRATA.**—In the issue of July 10th the following errors occur in Dr. S. T. Earle's paper. On page 201, line 29 first column and in lines 7 and 10 second column read *cornu* for *corner*.

### Medical Items.

The American Neurological Society will hold its next meeting at Long Branch, N. J., on July 21, 22, and 23.

The American Rhinological Association will hold its fourth annual meeting at St Louis, on Wednesday, October, 6, 1886.

The thirty-fifth annual meeting of The American Association for the Advancement of Science will be held at Buffalo, New York, August 18th.

The *N. Y. Medical Record* says, "the Pasteur Institute of this city has got to work and a boy, bitten some weeks ago 'by a dog supposed to be mad,' has been inoculated *secundum artem*."

William B. Atkinson, A.M., M.D., the well-known Secretary of the American Medical Association, has been elected Professor of Diseases of Children and Sanitary Science in the Faculty of the Medico-Chirurgical College of Philadelphia.

Dr. Ogle, the Registrar of Statistics in England, has found that the mortality among English physicians for three years from 1880 to 1882, was 25.53 per thousand, while that of barristers was 20.23 and clergyman 15.98 per thousand.

The honorary degree of Doctor of Laws has been conferred upon Dr. Oliver Wendell Holmes, by the Universities of Oxford, Cambridge and Edinburg. With these triple honors from the great Universities of Great Britain, Dr. Holmes may well sigh, like Alexander the Great, for more conquests.

To disguise the taste of quinine Dr. Hugo Engel recommends a mixture with one grain of quinine, of one grain of chloride of ammonium, and four grains of powdered licorice root. The same proportion of ammonium must be used for larger doses, but ten grains of the licorice will suffice for ten grains of quinine.

It is reported that his satanic majesty, while on a recent visit to this planet for a cargo of sulphur, was shown a sample of iodoform. He immediately countermanded the sulphur order, and substituted iodoform, saying, "Not in all my realms below does any perfume so please my senses." In other words, the odor of iodoform beats sheol.—*Canada Med. and Sur. Jour.*

Mr. Jonathan Hutchinson recommends in the *British Medical Journal* the use of a silver wire-loop, instead of either forceps or scoop, in the removal of foreign bodies from the ear. This method he claims is not only devoid of danger, but is both more easy and more efficient than any other plan. The method of procedure is to introduce the wire-loop gently into the ear, and to turn it about until it is believed to have gotten behind the foreign body.

The *Alabama Medical and Surgical Journal* is the title of a new medical monthly recently established in Birmingham, Ala. Drs. J. D. S. Davis and W. E. B. Davis, of that city are the editors in charge. Only a few years

ago Birmingham was literally hewn out of a "howling wilderness." It now numbers over 20,000 people, and is one of the most prosperous cities in the South. This effort upon her part to give the profession of her state a medical journal is in keeping with her marvellous enterprise in other directions.

The State of Kentucky appropriates only \$2500 per annum to the State Board of Health to protect the health and prevent disease among the people of the State, while \$6,000 was voted from her treasury to stamp out a single disease in a single locality and among a single herd of cattle. It appears in Kentucky that live stock is at a far higher premium than human stock. A pure bred bull will frequently command \$20,000 in Kentucky, whilst the average citizen is scarcely rated higher than a charge of powder. Things need reforming in the Grand Old State.

A small institution has been opened in New York City by one of the sisterhoods of the Protestant Episcopal Church, which is intended to receive those who are well enough to leave the large general hospitals, but who are not yet able to go to work. The institution is known as St. Andrew's Convalescent Hospital. It is quite apparent to those who are familiar with hospital work that such an institution will fill a genuine want in every large community. We learn that a similar institution is contemplated in this city, under the auspices of the Hospital Relief Association.

The College of Physicians and Surgeons of Baltimore is reported as being in a most flourishing condition, no less than one hundred and fifty students having been graduated from it in March last. This is no doubt due in a large measure to the very complete clinical advantages and facilities for practical research which the college offers, as it has under its exclusive control, besides three laboratories—physiological, pathological, and chemical—a general hospital, the Maryland Lying-in Asylum, the Woman's Hospital, and the City Dispensary.—*Gaillard's Medical Journal*, July 1886.

The Kentucky State Medical Society at its thirty-first annual meeting recently held at Winchester, Ky., elected the following officers for the ensuing year: Dr. W. H. Wathen, of Louisville, President, Dr. J. M. Harwood, of Shelbyville, Senior Vice-President; Dr. J. H. McKinley, of Winchester, Junior Vice-President; Dr. J. Steel Bailey, of Stanford, Permanent Secretary; Dr. F. C. Simpson, of Bardstown, Assistant Secretary; Dr. Edward Alcon, of Hustonville, Treasurer; Dr. J. G. Brooks, of Paducah, Chairman Committee of Arrangements; Drs. D. S. Reynolds of Louisville; A. W. Willis, of Winchester; A. Sargent, of Hopkinsville; J. H. Letcher, of Henderson; W. E. Poynter, of Midway; J. W. Harwood, of Shelbyville, Board of Censors. The next place of meeting will be Paducah, the third Wednesday in June, 1887.



Selected Articles.

ON THE NATURE OF SCROFULOUS GLANDS IN THE NECK AND THEIR SURGICAL\* TREATMENT.†

BY KENDAL FRANKS, F.R.C.S.I.,

Surgeon to the Adelaide Hospital, Dublin.

(Continued from last issue.)

My excuse for having gone at some length, and as briefly as I could, into the pathological aspect of the subject, must be that upon our view of the question in this light the further question of surgical treatment is based; and also that in most of the works in our own language the tubercular nature of the disease is not recognized sufficiently. In support of this assertion I will quote a few passages from some of the more recent surgical works which deal with the subject of scrofula and tubercle. In the first volume of Ashhurst's "International Encyclopædia of Surgery," p. 242, in the article on Scrofula and Tubercle, written by Mr. Butlin, and published in 1882, he thus speaks of the morbid anatomy of scrofula: "There is not in scrofula, as in tubercle, a pathological body, either microscopical or of larger size, peculiar to the disease. All the changes are those of inflammation; but the products of scrofulous inflammations may be analysed, chemically and histologically, without the discovery of any substance or structure which may not equally occur in any, or indeed in every, inflammation." This was no doubt written immediately before Koch's address before the Physiological Society of Berlin, but it does not even represent the position of the question as it stood for several years prior to the discovery of the bacillus. The identity of the two diseases had been fully recognized by leading pathologists, as I have endeavored to show; the only question waiting for solution being "What is tubercle?" Again, in Mr. Treves' work

on "Scrofula and its Gland Diseases," published also in 1882, p. 20, after giving the evidence for and against the identity of these diseases, he proceeds to discuss the value of the inoculation experiments, especially with respect to the conclusions drawn from them by M. Villemin. He then makes almost a pathetic appeal in favor of scrofula and its future distinctive existence. He says: "But even now some pathologists still advance the opinion (which I give in the words of M. Villemin) that 'tubercle alone gives tubercle by inoculation.' Those who retain this view are compelled to exclude from scrofula all its classical features; the caseous gland, the cold abscess, osteitis, periostitis, and 'white swellings;' and all that they can leave for the disease are a few superficial lesions, the products of which will in time be probably found to be inoculable, and then, for M. Villemin and his followers scrofula will be an extinct disease." Well, terrible as the alternative is, we must face it; and as we must now hold that "tubercle alone gives tubercle," and that, as the bacilli from scrofulous lymphatic glands, when inoculated, give rise to tubercle, we must also hold that scrofulous lymphatic glands are tubercular; Mr. Treves will have to accept his alternative and acknowledge that scrofula as a distinct disease has ceased to exist. Let me cite another extract, one from Dr. Clifford Allbutt's lecture on "Scrofulous Neck," as it illustrates the dawn of the tubercular aspect of the disease in these countries. He says in his lecture published last year, p. 12: "Our knowledge of the tubercle bacillus is as yet too young to tell us whether scrofulous neck always depends upon the introduction of the tubercle bacillus by way of the mucous membrane of throat or otherwise—too young, indeed, even to tell us whether the tubercle bacillus is an essential part of scrofulous neck at all. We know that it may be found there, and that scrofulous neck has of late years been regarded as morphologically tubercle, so that we are safe at least on the broad postulate that inoculation from sources of corrupt or caseating pus does very

\*From the London *Lancet*, June 19th, 1886.  
†Read before the Surgical Section of the Academy of Medicine of Ireland, April 16th, 1886.

commonly set up a more or less generalised tuberculosis." I do not wish to assert that every enlargement of the cervical lymphatic glands is tubercular. We eliminate in this discussion those forms of adenitis which are associated with various infectious and simple inflammatory processes; we omit the so-called rheumatic bubo which appears in otherwise perfectly healthy individuals, without discoverable cause, most frequently in the axillary and inguinal glands, and which often terminates in suppuration. In fact, only those affections of the gland are here discussed to which the term scrofulous is usually applied, and these we assert, are due to the specific action in them of the tubercle bacillus. The diagnosis in the early stage is extremely difficult, indeed sometimes impossible, between the tubercularly infected gland in the neck may enlarge from the irritation caused by a carious tooth, or an attack of tonsillitis, or a simple cold. But as the irritating cause disappears the swollen gland will subside, though sometimes it takes a long time to do so. But in the tubercular gland it is quite otherwise. The irritating cause may disappear or have been so slight as to escape notice, but the infected gland remains stationary for a time or continues to enlarge, and presently we find other glands following in its wake and enlarging too. In the early stage our only means of diagnosis is to wait, and what was at first obscure will soon be cleared up by the future progress of the case.

Now, to understand the process of infection in the cases referred to, we must for a moment look at some of the characteristics of the bacillus itself. It cannot develop in a temperature below 86° or above 106°; therefore, outside an animal body it cannot grow in this climate. Inside the body it grows and multiplies. A bacillus takes a month to reach its fullest development. It multiplies by fission, and by the formation of spores. These spores are much more resistant than the bacillus itself. Drying the bacilli or the spores does not destroy them. It is not therefore difficult to understand how easily the infection may

spread. The sputa of phthisical patients, for example, swarm with them. When these sputa dry, the bacilli and their spores, in a dry but active state, are scattered far and wide in the air, and may come in contact with a suitable soil whereon to develop. An ordinary healthy individual does not present this soil. The bacilli may be inhaled into his lungs, may be swallowed with his food or mixed up in his saliva, they may even lodge on some abraded mucous surface, and yet may do no harm. The antiseptic power of healthy living tissue is fully recognized. But there is undoubtedly some defect of constitution, some "vulnerability" of these tissues which we do not understand, which furnishes a fruitful soil. Call scrofula, if you will, the peculiarity of the soil on which the bacillus grows; but the seed itself and its growth, and the manifestations of its development, let us call tubercle. We shall thus have clear ideas, at least, as to what we mean; we shall not continue to confound together the soil, and the seed which grows on it. Now, look at the behavior of the bacillus when once it finds a local habitation congenial to it. As I have said, a bacillus requires nearly a month for its full development, and shows hardly any signs of growth under a week or ten days. During this period they may be cast off in the bronchi by the action of the cilia; in other regions they may be expelled with the secretion of the part. But suppose they gain an entrance through some abraded part—they are taken up by the lymphatic vessels and carried to a neighboring gland, or they may develop in the tissue where first they found a resting-place. In the case of the glands in the neck, we can generally trace the history back to some such local infection. Thus a child suffers from eczema of the head, and the child is of a delicate constitution; we are told it is scrofulous. Or the child has a purulent otorrhœa or ulcers in the mouth, or it suffers from a discharge from the nose. Later on, a gland in the neck, usually only on one side, enlarges. Or a young adult, and sometimes even one more advanced in life, suffers from a cold, from an attack



of tonsillitis, or from enlarged, sometimes caseating, follicles in the pharynx (and I have not infrequently traced it to this cause); and even after this ailment has subsided, and is perhaps forgotten, a gland, or more, begins to swell. Long after the exciting cause has ceased to act, the gland either remains *in statu quo*, hard, nodulated, movable; or it may develop rapidly all the series of phenomena which are known as scrofulous. Other glands enlarge, and frequently we find all the glands on one or on both sides of the neck sharing in the process. This whole series of events are explained by what we know of the behavior of the tubercle bacillus. By some such channel as I have mentioned the bacillus enters; it is taken up in the lymph streams, and is arrested by the first lymphatic gland it meets. In such cases too much importance cannot be attributed to the functions of the lymphatic glands. They act as defensive outposts, as filters to free the lymph of infective and deleterious matters which it may contain, but in doing so they themselves suffer. In process of time the bacillus grows within them, multiplies, and gives rise to the formation of true tubercle. These tubercle become yellow in the centre, they coalesce, and in process of time form a caseous mass. At this period one of three things may happen—in other words, the gland may follow one of the proverbial “three courses.” First, it may get well, though this is not a frequent result. Secondly, it may suppurate,\* make its way to the surface, and discharge its contents, and this may end in cure. Or, thirdly, it may extend, infecting gland after gland. Even here, too, nature may accomplish a cure by a slow process of successive suppuration, which may eventually eliminate the disease. But should nature fail to do so, the last gland between the bacilli and the general circulation may become infected, the last outwork of defence may be carried, and then the whole system is exposed to general infection, and a more or less acute general

tuberculosis results. But what is to determine which of these three courses shall be followed? It seems to depend on one or other of two factors: firstly, on the number of the bacilli which have gained access to the gland; secondly, on the constitution of the patient. Koch has shown that it is of the greatest significance whether the infection be produced by a few bacilli or a by a large number. In his inoculation experiments, he found that a large number of bacilli, after first producing a diffuse caseous infiltration, both at site of injection and in the neighboring glands gave rise rapidly to general tuberculosis. If the number of bacilli introduced were smaller, the length of time which preceded general infection became longer; and when the bacilli were few, this period might be very long, or in some cases generalization might not occur at all. In spontaneous tubercular infection in man the dose is usually small, though sometimes it is often repeated; and hence it is that in tuberculosis of the glands in the neck general infection of the system most frequently does not occur. The constitutional condition of the patient plays a part only second to the strength of the dose received. I have already alluded to the fact, recognized by all, that a certain state of the system, a certain constitutional susceptibility, is necessary, in order that an individual may contract tubercular disease—that is, that every person does not offer a suitable soil for the growth of the bacillus. What is equally true is that persons may possess this vulnerability in different degrees, and, moreover, that the same person does not afford at all times the same suitability of soil. Clinical experience has taught us this over and over again, and upon these axioms are based all our constitutional methods of treatment, the importance of which in every case cannot be over-estimated. In every case, whether we adopt surgical measures or not, we should aim at so improving the health of the patient by those means, which it is not within the scope of this paper to discuss, that to the best of our ability we shall put him into a condition to contest successfully with the unseen foes.

\*This suppuration is not a necessary result of caseation, but is probably due to the entrance of some form of micrococcus by the same or some other channel as that by which the bacillus entered.

Taking, now, these two factors, we see that even when a gland has become infected we may hope for spontaneous resolution, provided that the infecting dose has been small, and provided the patient's constitution has so improved that the gland tissue is healthy enough to cope with the bacillus. Now what do we observe in such a case? The bacilli gradually disappear from the caseous mass, and may not be finally found at all, and the broken-down tissue may be absorbed, or it may calcify, and recovery ensue. This is unfortunately a rare occurrence. But supposing these factors are not sufficiently strong to bring about such a desirable end, the patient may eliminate the disease by a process of suppuration. The caseous masses in the gland—and they are usually multiple—begin to show evidence in the centre of suppuration. This may go on to a considerable extent before any external symptoms of suppuration appear. So that because a gland is hard and movable, and is not tender to touch, we cannot assume that that gland does not contain many central abscesses of small size. Gradually these abscesses coalesce; the gland becomes tender; it enlarges more and more; inflammation extends to its capsule and to the neighboring parts, and soon adhesions form. By slow degrees the skin over it becomes involved; it becomes firmly adherent; it thins; the abscess opens and discharges, and a sinus is left, which may, and generally does, keep open for weeks or months discharging a thin pus with cheesy matter contained in it; and when it heals it leaves behind it an ugly and disfiguring and puckered scar. But, even so, the patient is well quit of his disease. More frequently, however, the bacillus has made its way into neighboring glands. One by one these enlarge, and the same slow process of suppuration begins; another sinus forms through unhealthy purplish skin, and another scar is left; and the cycle is repeated till the whole neck is seamed and unsightly. Is not this a true picture of the disease, one with which we are to commonly familiar? If more were needed to paint

it in its true colors, let me give it in the eloquent words of Dr. Clifford Allbutt; "That the ugly finger of scrofula should be laid chiefly upon children, young men, and maidens, has this pathos in it, that it disfigures them at the spring time of life—at that time when hope and promise make all life precious, and all death seem the loss of untold treasure; when beauty and gaiety have their fleeting day, and for the loss of them the world is poorer."

But even while the local process of decay is going on the general system is not safe from its ravages. As long as these caseous masses of tubercle exist in the body, so long must we ever bear in mind that the danger of generalisation is possible. But even if we were sure that by repeated and prolonged suppurations the danger of extension were removed and the bacilli expelled, the scarring of the neck is not the least consequence which may follow. Remember that this disease would never have originated but for a peculiar constitutional susceptibility. Will that susceptibility be diminished by months or years of suffering? Will it not rather be enormously increased? During this period "septic matters are absorbed into the blood, recurrent and variable hectic dissipation the appetite, flesh, and strength, so that the patient finds himself at the end of it all, if not unsound in his internal organs, at any rate a far worse man than he would have been had this trial been spared him."<sup>†</sup> Let him become again exposed to tubercular infection, let him breathe impure air impregnated with tubercular poison, and who shall say that he will escape with healthy lungs? It is believed by some that in subjects predisposed to scrofula the involment of the glands in youth affords them some sort of protection against phthisis subsequently. But this view cannot be upheld. Only the other day a girl came into hospital with extensive disease of both lungs, and her neck was seamed with old scrofulous scars. The worst case of tuberculous glands in the neck I ever saw was in a girl who died of phthisis.

<sup>†</sup>Clifford Allbutt: *op. cit.*, p. 12.



Such then, being the nature of these so-called scrofulous glands, and such the consequences which we have to face, I think I am justified in asserting that the time has come, when the treatment of this disease, except in its earliest stage perhaps, should pass from the domain of the physician, and should be entrusted to the surgeon. In the earlier stage, while still the diagnosis remains uncertain, the treatment is one of expectancy, tempered by constitutional measures. But when once the diagnosis is assured, and there is no evidence that resolution is likely to take place, bearing in mind the nature of the disease we have to deal with, and the consequences which may follow from waiting too long, I am strongly convinced that the surgeon's art should intervene to assist Nature, and to do that quickly, which unassisted she would do if she could, but often fails in accomplishing, or only succeeds when her victory has cost her dear. When as yet the poison has infected but one or two glands, we have good grounds to hope that by their removal we may eliminate from the system every focus of infection. Every case is not suitable for the same method of treatment, and in some cases we have little choice left to us as to what method we shall adopt. Of all the various surgical methods at different times suggested, there are three which I shall especially refer to as being the best. Each one is applicable to a different class of cases, and although they have been applied indiscriminately by their special advocates, I think there are well-marked lines which should divide those cases in which a special method is applicable from those in which it is not. These three methods are (1) scooping, (2) cautery puncture, and (3) excision.

Of the first method—scooping—I need say but little, as the subject has been very fully and ably discussed in a lecture by Mr. Teale, which was published last year.† I shall merely quote a few of his conclusions, with which I entirely agree. 1. "That surgery can secure the

healing in a few weeks of gland cavities, even though they have existed for years, and of wounds resulting from the removal of caseous and suppurating glands."

2. "That in dealing with sinuses, gland abscesses, and decayed or semi-decayed lymphatic glands, the action of the surgeon must be vigorous and thorough."

7. "That in dealing with a sinus the channel should be enlarged by the knife or by Bigelow's dilator, and the whole of its granulating surface should be scraped off. Where a sinus is shallow and covered by thin blue skin, this imperfect covering should be rasped away by the scraper, and any cutaneous overhanging edges should be trimmed off by the scissors."

8. "That, in dealing with a sinus or an abscess, the surgeon should not rest content until he has discovered and eradicated the gland, always remembering that if it be not obvious there is sure to be a small track leading through the deep fascia to the missing gland. This opening should be enlarged so as to admit the spoon of Lister's scraper." These conclusions which I have quoted explain the classes of cases to which, I think, this method is suitable, and to which I believe it should be restricted. These classes embrace cases in which sinuses exist, or in which a superficial abscess communicates through an opening in the cervical fascia with a suppurating and caseous gland beneath. It is also sometimes a good treatment to adopt when the changes going on inside a gland have given rise to inflammation of its capsule and to the formation of firm adhesions between it and its surrounding tissues. For in these cases enucleation of the entire gland is extremely difficult. I have employed this method in many cases, and my experience of it has strongly impressed me with the belief that the classes of cases I have mentioned are those to which the method should be restricted. For in all these cases the method of excision is fraught with too much difficulty to authorise us to adopt it in preference to this apparently simpler plan; but, on the other hand, it should not be extended to cases in which enucleation can be readily performed, and for this reason. In most of these

†On Scrofulous Neck, by T. Clifford Allbutt; and on Surgery of Scrofulous Glands, by T. Pridgin Teale. 1885.

tuberculous glands, the gland capsule shares in the disease, and in the scooping operation this is necessarily left behind; moreover, there may be, and there frequently are, enlarged and tuberculous glands in the neighborhood, which have not yet softened. These escape the spoon, and later on become the foci from which fresh infection starts. Of much less importance is the fact that the incision after inucleation seldom takes more days to heal than that after scooping takes weeks. On these several grounds, I hold that the scooping operation should *only* be done in those cases in which excision is inapplicable.

The second method of treatment is that by cauterization. It has found its chief advocate in these countries in Mr. Treves,<sup>§</sup> and it has also found much favor in France. Mr. Treves expresses the opinion that it is "one of the very best operative measures at the disposal of the surgeon for the cure of scrofulous glands." He thus describes it:—"In this operation I make use of a thermo-cautery point about as thick round as a No. 7 catheter. This point, having been heated to a bright-red heat, is thrust through the skin into the substance of the gland, and passed in three or four directions in the body of the tumor before it is removed.....If no pus or cheesy matter follows the removal of the iron a simple zinc dressing may be applied, but if any such matters escape then a poultice should be ordered.....It is more adapted for adherent than for movable glands. This method I have lately employed, and in certain cases I think it should be productive of good. Its *modus operandi* would seem to be that the intense heat destroys the tubercle bacilli and their products, and it leaves a channel for their escape externally which does not allow of extravasation into the neighboring cellular tissue. It seems to me that in softened adherent glands, it would probably be more effective than the method of scooping.

The third method of dealing in a radical manner with these tuberculous glands is by excision. It is specially suitable

in those cases where the glands are not adherent. The operation is easier the harder the glands are—that is, the less advanced they are in the process of supuration. The great advantages I claim for this method are that we can in most cases entirely remove all the affected parts, including the capsule of the gland. The wound is a clean incision, mostly through healthy skin, and therefore, with strict antisepsis, heals by first intention, and leaves a scar which in process of time becomes white and often unnoticeable. When the glands are non-adherent, they can be enucleated with great ease. On the 8th of this month, through an incision an inch and three-quarters long, I removed eight glands three as large as walnuts, and all of them caseous. Seven days after, the wound was healed, and the scar even then scarcely noticeable. But when the tubercular process has been allowed to run its course for a long time, and adhesions have formed, then the real difficulty is experienced, and often a tedious dissection is required before the diseased glands can be removed. And here let me say that this difficulty is often of our own making. We meet a case in which two or three glands in the neck are swollen and hard. A careful inquiry into the history of the case will satisfy us that the glands are scrofulous. But instead of dealing with them at once, we allow the disease to spread, more glands to become infected, and adhesions to form, whilst we wait. Wait for what? To try the effects of this or that external application, painting with iodine, or a host of other remedies, which experience should have taught us in that stage are no remedies at all. Sometimes the delay is due to our unwillingness to make a cut which may leave a scar, and then nature takes the matter in hand, the gland softens, an abscess forms, and the end of it is that a far worse scar is left than would have resulted from timely intervention. Besides, all this time other glands are preparing to go through the same process. Such things ought not to be. What I maintain is, that the earlier we attack these glands the less we shall have to do, and the smaller and

<sup>§</sup>Scrofula and its Gland Diseases, p. 193. 1882.



more insignificant the scar will be; and, what is more important still, the focus of the disease may be got rid of through quite a small opening. Often, however, we have at least this satisfaction, that we cannot blame ourselves if the disease has become extensive. It may be so when first we see the patient, but even in the most extensive cases of scrofulous glands we may hope for a cure by surgical art. I have notes of fifteen patients from whom I excised tuberculous glands. Two were operated on twice and two three times, making in all twenty-one operations. Some of these were comparatively simple cases, two or three glands only requiring removal. Some of the cases were most extensive, and of these three present points of special interest.

The first case was that of a boy aged seventeen, whose neck was enormously swollen on the right side, owing to the enlargement of the glandulæ concatenatæ and sub-maxillary glands. I operated on him twice. The first time was on June 12th, 1883. A curved incision, about four inches long, was made behind the sterno-mastoid muscle, and all the enlarged glands removed. They were all caseous, several presenting centres of suppuration in the middle of the cheesy masses. I mention his case because he was attacked with erysipelas three days after operation. The erysipelas began low down on his back, spread gradually over his whole body, with the exception of the parts underneath the antiseptic dressings. This part remained healthy throughout, and the wound healed well. Some months after I removed the sub-maxillary glands. A similar mishap occurred in a second case, but both made perfect recoveries.

The second case I wish to mention was that of a married woman, aged twenty-three, who presented a long chain of glands extending from behind the left ear to the clavicle. They were movable and hard in the upper two-thirds, but below they were soft and suppurating. I excised them all at one operation on April 3rd, 1884. The abscess cavity was scraped out, and a drainage-tube inserted through a counter opening close to the clavicle, the wound being it-

self completely closed. The dressings were not disturbed till the seventh day, when the wound was quite healed. The drainage-tube was removed, and the sinus was completely healed on the fifteenth day. She left the hospital three days later. I saw her again a few months ago, a year and three-quarters after operation. There were no more enlarged glands, and the incision was reduced to a fine white pliant scar.

The last case to which I shall refer is that of a girl aged eighteen, who was studying to become a schoolmistress, but was rejected on the ground of health, as the left side of her neck was bulged out with a large number of swollen glands. She was greatly disfigured. I operated on the 29th of April, 1884. The incision reached from the mastoid process to within an inch of the clavicle. All the superficial and deep glands were involved, those lying underneath the sterno-mastoid muscle being very difficult to enucleate. I removed in all forty-eight glands at this operation. She made a slow recovery, but a good one. I saw her the other day, nearly two years after operation. There is a long scar, but it is soft, white, and flexible; and she can so arrange her hair as to make it almost imperceptible. She is in excellent health, and has had no return of the disease; in fact, we might expect, it is not possible to feel any glands in that side of the neck. I mention this case especially as showing that excision can be safely done, even in such an extreme case.

Before concluding this paper, there is an objection which I should like to answer—an objection which I have heard raised, especially in regard to these extensive operations; and it is this: Is it not a very serious matter to interfere to any great extent with the lymphatic system in the neck? That objection is entirely theoretical; I have not seen in any of the cases on which I have operated any evil consequence referable to this cause. Besides, we must bear in mind that caseous glands are, to all intents and purposes, functionally destroyed. If there is any reason in the objection at all, the blame must be left at the door, in the first instance, of the tuber-

cular affection; and, secondly, at the door of those, be they doctors or patients, who allow the disease to progress to such an extent—a disease which, I trust, have shown can be arrested in its early stages by the timely and judicious intervention of surgical art.

### Society Reports.

## TRANSACTIONS OF THE CHICAGO GYNÆCOLOGICAL SOCIETY.

STATED MEETING MAY 28, 1886.

I.—LAWSON TAIT. *Abdominal Section for Pelvic Abscess.*

II.—NELSON. *Specimens Removed from a Case of Supernumerary Digits.*

The President, DANIEL T. NELSON, M.D., in the Chair.

I.—The Secretary, DR. EDWARD WARREN SAWYER, read the following letter from Mr. Lawson Tait.

7, THE CRESENT, BIRMINGHAM,  
April 14, 1886.

MY DEAR DR. NELSON:—If not too late, I should like to take part in the discussion which was entered into at the Gynæcological Society of your city upon Abdominal Section for Pelvic Abscess. My remarks, of course, are discursive and not very conclusive, because they are based upon only a few points to which I want to draw attention.

The first is this: I object to the use of words ending in *otomy*, to mean various operations all of which are practically identical in character but different in detail and not one of which can have any exclusive or absolute identification by any particular name. Thus Dr. Christian Fenger, in the discussion, objects to the use of the word laparotomy, and he introduces another word which is perfectly new to me and I hope it will never be used again: it is *oncotomy*. Dr. Fenger objects to laparotomy in a sense where I certainly have no objections, and his very objections only show

how utterly absurd all these words are. There really ought not to be any such word as laparotomy in existence, because the signification of its derivatives in the use of the people who spoke the language is such that it could not by any human ingenuity be applied to any modern surgical proceeding. Now the words "abdominal section" are sufficiently English to be understood by everybody, and they are sufficiently distinctive to enable us to understand at once that when they are used the peritoneum is opened. I therefore wish through your powerful society to protest against the use of all these stupid words of Greek formation. I wish also to protest against the absurd distinctions drawn by Sanger which are quoted by Dr. Fenger on the subject of pelvic abscess.

He distinguishes six kinds of salpingitis.

1. *Septic*, the existence of which I entirely dispute as a specific ailment.

2. *Tuberculous*, which again I deny except that it has an existence as the third and contracting stage of pyosalpinx.

3. *Syphilitic*, not one particle of evidence of this have I even seen.

4. *Actino-Mycotic*, which is an equally ridiculous subdivision, based on mere theory, not on fact.

5. *Gonorrhœal*, to which the great bulk of the cases belong.

6. *A mixed form*. Instead of this sixth, or mixed form, I would say that there are a great many cases to which we cannot attribute any actual origin, a number of cases occurring in virgins where the existence of gonorrhœa would be an impossibility, and where there was no puerperal mischief.

Dr. Fenger's paper has always seemed to me to be an illustration of the German savant evolving the descriptions of the camel out of his own consciousness. My descriptions, on the other hand, are taken from some hundreds of cases upon which I have performed operations and the history of which I know as completely as it is possible to obtain information.

In Dr. Reeves Jackson's paper there are two points to which I want specially to draw attention, and they are not of



much importance because they are chiefly questions personal to myself.

The first is a passage in which it is said "Lawson Tait, of Birmingham, and Martin, of Berlin, were the first who attempted to prevent the terrible contingencies of pelvic inflammations by attacking the disease at its original seat; Lawson Tait removed the suppurating uterine bandages, Martin operated for suppurating periuterine hæmatocele. Tait operated for a suppurating hæmatoma of the right Fallopian tube in 1878, and he removed both tubes for pyosalpinx, and an ovary for abscess in 1885. In 1885 Martin performed laparotomy in three cases of intraperitoneal hæmatoma, namely, retrouterine hæmatocele." Now accuracy of date in a matter of this kind is rather important for one's own personal reputation, and Dr. Reeves Jackson has underestimated my claim for priority by at least seven years. The first operation which I performed for suppuration of the uterine appendages was done on the 11th of February, 1872, and there will be found in the last edition of my book on "Diseases of the Ovaries," twenty-two cases which I had performed up to the middle of August, 1882, without a death. Since then I have operated upon hundreds. The first case of suppurating hæmatocele which I operated upon is published in detail in the same book; it was in February, 1879, and since then I have operated upon thirty-two cases without a death, and all have been completely cured. It will thus be seen that in none of these matters have the German surgeons approached English surgery as rivals in priority. They have been mere followers in every particular, and I regret to say their following has been practiced without that recognition to which our priority gives us every just claim.

The second point is that in which I find Dr. Byford speaking in terms of my own work which no words of mine can sufficiently recognize or express my appreciation of, and here certainly his words of caution are worthy of a little note. What I fear, in fact what I already feel, is that the remarkable success

which I have had, and of which Dr. Byford speaks in such strong terms, is really leading astray those whose opportunities have not been as my own, into the belief that the work is easy, simple, easily acquired and free from risk. It is not so, and unless those who practice it choose to follow me in the rigid precautions and immense care which I give, not only to the mere performance of the operation, but to the surroundings of my patients and to every detail in connection with them, they will not obtain, they must not expect, the success which I have had. I have said that I fear, in fact, I already feel, that this success of mine is leading people astray, and I want to urge in the name of humanity, as well as for the sake of the art we practice, that there should be less of the indiscriminate rushing into this kind of work which has been already deplored on both sides of the Atlantic.

I am, etc.,

LAWSON TAIT.

#### DISCUSSION.

*Dr. A. Reeves Jackson* said: We ought, I am sure, to feel honored by having among us in spirit, if not in person, so eminent a man as the writer of this letter. Lawson Tait is in some respects the greatest living surgeon, a Gamaliel at whose feet we all find ourselves sitting; and, withal, a man so observant that not a single gynæcological sparrow falls in any part of the world unnoticed by him. I must plead "not guilty" to the charge—made against me by Mr. Tait—of inaccuracy regarding the date of his first laparotomy for pelvic abscess,—the remarks upon this point having been made by another, and not by me. As stated in the letter, his first operation of this nature was done February 11, 1872, at Birmingham, on a patient of Mr. Hallwright. I am sure that Mr. Tait will not for a moment suppose that any of us would willingly do injustice to one whom we all esteem so highly, and from whom many of us have been recipients of acts of kindness and courtesy.

In regards to the justice of Mr. Tait's criticism on the prevalent use of the words ending in "otomy" I do not feel like being an arbiter. Technical words are frequently necessary, and yet, as a general rule, I think it preferable to use simple language. The ordinary English words are commonly sufficient to answer all the purposes of language. Besides, large and unusual words are sometimes embarrassing. When, some weeks ago, Dr. Fenger charged me with performing an "oncotomy" I was afraid that I had done something very dreadful, and the worse because I did it without knowing it. I felt very much as the fisherwoman did when Daniel O'Connell in response to her volley of ordinary, undecorated profanity called her a parallelogram. The fisherwoman did not know what to say, and I could not reply; we both had evidently lost the thread of the discussion. I am glad that Mr. Tait speaks so strongly in regard to the tendency now so frequently indulged in, to perform laparotomies, and that he is willing to correct to some extent by his words the mischief that has been done by his powerful and successful work. It seems that when some persons visit Mr. Tait and witness his success and simple but effective methods, they come back thinking life is a blank unless they can own and manage an abdominal hospital and spend the remainder of their days in the cheerful occupation of removing uteri and ovaries.

*Dr. Christian Fenger* said: The letter which Mr. Lawson Tait wrote to Dr. Nelson relates in a number of points to my paper on "Laparotomy for Periuterine Abscess" as well as to some remarks which I made before the Society in a previous discussion. I must, therefore, beg the fellows of the Society to bear with me if I take up a little of their time in answering Mr. Tait's letter.

Discussing Dr. A. Reeves Jackson's paper, I objected to calling the operation in question a laparotomy. According to the doctor's description of the case, he had opened an abscess which was adherent to the anterior abdominal wall. He had consequently simply performed an oncotomy, an operation which, not-

withstanding the division of the abdominal wall, does not differ materially from opening a deep-seated abscess in any other region of the body, as *ex. gr.* in an extremity.

Whether opening the abdominal or peritoneal cavity be termed laparotomy or abdominal section or *Bauch-Schnitt*, is of course a matter of indifference, provided only that the meaning of the word be agreed upon. There is but one way of getting at the signification of a medical term, and that is by learning in what sense the term is employed in the medical literature of the different nations.

I must again maintain that laparotomy is not merely section of the abdominal parietes, but that the word implies opening of the general peritoneal cavity with a view to perform some operation within that cavity. (See *Linhardt's Operationslehre*. Wien 1862, p. 705, and *Eulenburg, Realencyclopædie*, Bd. II, p. 37.) French authors occasionally use the word gastrotomy instead of laparotomy. Recently the operation has been called peritonotomy, which on account of its correctness should perhaps be preferred to the other terms.

It is of importance to distinguish between a laparotomy and the evacuation of a limited abscess by simply incising the abdominal wall. The two operations differ widely as to their consequent dangers. Where the general peritoneal cavity is opened, a well-known series of precautionary measures is required before and during the operation, in order to protect the patient from general septic peritonitis.

Where an incision through the abdominal parietes leads directly into a limited abscess-cavity, the precautionary measures essential to laparotomy may be dispensed with; the general peritoneal cavity is not opened and there is no fear of general peritonitis. In the latter operation the peritoneum is not seen or not taken notice of, the incision-wound is left open and the limited cavity washed out and drained.

In every country medical authors hold these two operations apart. Opening a perityphlitic abscess, an adherent hepatic



abscess or a parametritic abscess above Poupart's ligament is never spoken of as a laparotomy. Whenever we hear or read of a man having performed a series of laparotomies we naturally suppose that he is experienced in performing intraperitoneal operations. Now, many a surgeon has opened a large number of intra-abdominal abscesses and has never seen a peritoneal cavity.

It is evidently important properly to limit the meaning of the term laparotomy; else we may misunderstand the description of a given case, and the statistics of laparotomies will necessarily be rendered valueless.

The next point Mr. Lawson Tait remarks upon is the question of priority of operating for pelvic hæmatocele.

By the mistake of Mr. Tait, part of what I said in the discussion of Dr. Jackson's paper is ascribed to the paper itself, I am thus quoted in his letter.

"Lawson Tait, of Birmingham, and Martin, of Berlin, were the first who attempted to prevent the terrible consequences of pelvic inflammation by attacking the disease at its original seat. Lawson Tait removed the suppurating uterine appendices; Martin operated for suppurating periuterine hæmatocele."

In the discussion I stated the dates at which Tait and Martin performed their respective operations. By a typographical error the dates appeared wrong in some of the copies of the transactions of the Society. 1885 instead of 1872 was given as the date of Tait's first laparotomy for abscess of the ovary, and 1885 instead of 1876 as that of Martin's first laparotomy for extraperitoneal hæmatocele.

Considering my remarks as a whole and examining my references to the literature on the subject a careful reader would not have failed to recognize in the wrongly printed dates a typographical error.

Lawson Tait performed his first laparotomy for extraperitoneal hæmatocele in February, 1879. (See Lawson Tait: *Diseases of the Ovaries*. 4th Edition. London, 1883, p. 346, and Tait's letter.)

Martin performed the same operation

for the first time in 1877, and a second time on the 31st of January, 1879. (See Martin: *Das extraperitoneale periuterine Hæmatom*. Zeitschrift fuer Geburtshilfe und Gynekologie. VIII Bd., Hft II, 1882, p. 476.)

It will thus be seen that my statements concerning priority were correct. In the discussion of Dr. Jackson's paper I quoted Säger's classification of pelvic inflammations. In criticizing it, Mr. Lawson Tait speaks of "absurd distinctions." I wish to repeat that I regard Säger's classification as complete and correct and in accordance with the laws governing inflammatory processes in all organs of the body.

To Mr. Lawson Tait's manner of criticizing my little paper "On Chronic Periuterine Abscess and its Treatment by Laparotomy," which appeared in the May number of the *Annals of Surgery* 1885, there is but one answer.

Like all published articles it is open to criticism. If anybody should wish to attack it, I am ready to enter into a discussion of it, provided that tangible objections to it be brought forward.

II.—The President exhibited specimens removed from

#### A CASE OF SUPERNUMERARY DIGITS.

He said: While I know the condition is not exceedingly rare, I thought the specimen was worthy of presentation to the Society. The specimen consists simply of two supernumerary little fingers, which I found in a beautiful, healthy baby just after it was born, attached by small pedicles, consisting simply of the skin and the vessels needed to supply them, about the middle of first phalanx of the little finger; the pedicles were perhaps one-sixteenth of an inch in length, just long enough to ligature. They look like little beans; the finger nails are fairly developed in both. They were very vascular. They looked, before removal, like bangles. This was the sixth pregnancy; the other children were all perfect; no other case of this condition in the family that is known. The condition is usually hereditary. In one there is a very good nail

formed, upon the other there is only a slight nail. The mother is in good vigor and health. They were united to the larger little finger about the middle of first phalanx—one was just about the middle of the phalanx, on the outer border; the other, half way between the middle line and the outer border. They both feel as if there are bones in them—two phalanges in each, the third being represented by the pedicle.

### Book Reviews.

DISEASES OF THE DIGESTIVE ORGANS IN INFANCY AND CHILDHOOD. By LOUIS STARR, M.D., of Philadelphia. P. Blakiston, Son & Co., 1886.

The advent of Dr. Starr's book will be hailed with delight by those physicians who are unfortunate enough to have to remain in town during the hot months. The subject is important and difficult, and well worth separate consideration.

PART I.—On the Investigation of Disease has been carefully prepared and the young practitioner will find it worthy of his attention. The author while he describes with minuteness and accuracy the *Facies* and *Decubitus* of the child in health and disease, lays, we think, too much stress on trivial departures from the normal and does not reflect that a child may sometimes cry from hereditary 'cussedness' when it is neither hungry nor has earache.

The section on Physical examination is admirable and shows the result of careful observation and wide experience.

PART II.—Comprises Diseases of the Digestive Organs, the first chapter being devoted to affections of the mouth and throat. The author is especially happy in his description of the morbid appearances of the various diseases of the mouth, and while there is nothing new in his treatment, the formulæ are reliable and have evidently been carefully selected. In the treatment of eczema, which is spoken of under the

head of dentition, a bare mention is made of what in our hands has proved the best of the local applications, salicylic acid; nor does there appear any mention of a remedy recently brought forward and certainly of value, the frequent administration of small doses of ol. ricini. In treating the throat the author uses nitrate of silver rather more freely than we would care to do with children.

The most valuable part of the book is the section on Diseases of Stomach and Intestines, and we would call attention to the excellent article on enterocolitis, the symptoms of which are very graphically described on p. 164.

Cholera Infantum is noticed in a brief and rather unsatisfactory manner, and the author takes a gloomy view of the prognosis. There is a clear and concise description of the liver, followed by an account of the affections of the peritoneum most commonly met with in children.

PART III.—Which concludes the volume is devoted to the general management of children, and is full of valuable and practical suggestions as to bathing, feeding, clothing, and so on. It would have improved the arrangement of the book to have had this section follow the one on the Investigation of Disease.

While we might criticise the tendency to utter self-evident truths, the general style of the author is good, and the book bears marks of careful preparation.

We feel sure that Dr. Starr's labor in this important direction will be fully appreciated, and we recommend the book most heartily to the profession.

The autopsy of the late King Ludwig, of Bavaria, confirmed the view expressed by the alienists as to his mental condition, and of their unfavorable prognosis. Extensive degenerative changes were found in his skull, brain and its membranes, consisting in part of abnormal development, partly of chronic inflammation of old and recent date. The most lamented feature in connection with the death of the king is the fact that his suicide was attended with the loss of the great benefactor to science, Dr. Gudden, his physician.



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BALTIMORE, JULY 24, 1886.

Editorial.

SOME OF THE ADVANCES IN BACTERIOLOGY.—The domain of bacteriological research has developed into such a wide one, and the publications upon the subject have been so numerous and their sources so widely distributed, that it has become essential for workers in this branch to possess some index by which they could conveniently acquaint themselves with the nature of the contributions that are constantly being added to our knowledge on this subject. The *Jahresbericht über die Fortschritte in der Lehre von den Pathogenen Microorganismen*, edited under the direction of Professor P. Baumgarten, and the first number of which is complete for the year 1885, we think meets these requirements.

This volume contains a concise abstract of all the publications upon the subject presented during the past year.

Not a few of these abstracts present considerable of interest to the general practitioner of medicine as well as to the bacteriologist, and though mention of the more prominent among the number has already been made, we will take the liberty of running over, in a brief way, some of the results arrived at in the experimental study of diseases that are constantly brought under our notice.

The etiology of phlegmonous inflammations and acute pus formations has always been a subject of considerable interest. The origin of these pathological

processes being held by some to invariably be a microorganism, while other observers have demonstrated the possibility of such formations as a result of chemical irritation alone.

Probably the most complete contribution upon this subject up to the present time is that of Passet, who published a monograph entitled "Untersuchungen über die Ätiologie der eitrigen Phlegmone des Menschen." By means of the plate method of Koch he has been enabled to isolate in pure cultures eight different organisms from the pus of thirty-three cases examined.

Of these eight organisms, three of them he finds to be staphylococci, each producing, when grown upon artificial media, different colored colonies. These he names, according to its color, *staphylococcus aureus*, *albus* and *citreus*. The fourth one always forms into chains and is, in consequence, called *streptococcus pyogenus*. The fifth, he states, is in all respects identical with the pneumonia-coccus described by Friedländer. The sixth produces a fetid odor and is called *bacillus pyogenus fetidus*. The seventh and eighth are the *staphylococcus citreus albus* and *flavus*.

It is of interest that he has isolated from kitchen waste water the *staphylococcus aureus*, which is the organism most frequently found in the inflammation about the nails of persons whose occupations necessitate the frequent immersion of their hands in these slops or dish washings. In two cases he found the organism which he describes as similar to Friedländer's pneumonia-coccus; in one of these it occurred alone in an acute abscess in the lumbar region, and in the other case it occurred, along with another organism, in an inflamed knee-joint that existed at the same time that the patient's lung was in a state of croupous pneumonic inflammation. He has also turned his attention to the question of pus formations without the presence of microorganisms, and concludes that he agrees with result of experiments upon this subject made by Councilman:—that pus formations can occur without the presence of living organisms.

Councilman's experiments were made by introducing beneath the skin of animals, under antiseptic precautions, sterilized glass capsules filled with different irritating substances, such as croton oil, &c. After the wound had entirely healed and there remained absolutely no evidence of inflammation about the point of introduction, the glass capsule was fractured, and by the liberation of its contents there were set up acute pus formations, in which *no* microorganisms could be detected.

In the same section of the *Sahresbericht* we find an abstract from the monograph by Bumm upon the "Gonococcus of Neisser." His experiments lead him to corroborate the work of Neisser—that the organism is a diplococcus (divides always into pairs) and that its common habitat in gonorrhœal secretions is the protoplasm of the pus cells. He finds it in all gonorrhœal inflammations of the urethra, the conjunctiva, the cervix uteri and in gonorrhœal joint inflammations. He is convinced that it is the etiological factor in ophthalmia of the new born, as he found it in 26 of these cases in which the disease had existed for various periods of from 36 hours to 32 days.

His cultivation experiments were unsatisfactory until it occurred to him to try human blood-serum as a culture medium. He has employed a very ingenious means for obtaining it. He gets it from the human placenta by severing the cord and leaving the placental end unligated. The contractions of the uterus upon the placenta forces a greater or less amount of blood from the vessels of the cord, and he is thus enabled to collect from 15 to 20 c. c. of clear human serum.

He states that the gonococcus is very fastidious as to the medium upon which it grows, but that it gives entire satisfaction in its behavior upon solidified human serum.

His inoculation experiments upon young cats, like those of Neisser, Leistikow-Löffler and Krause gave only negative results. The introduction, however, of a small portion of the third generation of a pure culture of the gon-

ococcus into the healthy urethra of a woman, lighted up a typical gonorrhœal urethritis with an acute stage of three weeks, and the cure of which was only effected after a period of six weeks, notwithstanding the daily application of a 1 per cent. nitrate of silver solution.

Since the publication of Neisser's original paper there has been much doubt expressed as to the accuracy of his observations, and no small amount of experimental evidence has been produced to combat his results. That the gonococcus is an organism very difficult to cultivate, as is seen by the experiments of Bumm, we think entirely explains the erroneous position occupied by Neisser's opponents.

There is no room for doubt that the organisms with which these experimenters were working and which, without presenting any special difficulties in their cultivation, grew not only as diplococci but in pairs and chains, &c., were none other than the common organisms of pus described by Passet. In all probability the gonococcus was present in the original material along with these other organisms, but when its cultivation was commenced it went to ground because of unfavorable pabulum, while the other organisms grew and were mistaken for the micrococcus described as the etiological factor in gonorrhœa. Inoculation of these organisms into the healthy urethra necessarily failed to produce the disease, and in consequence, doubt was expressed as to the accuracy of Neisser's observations.

### Miscellany.

RINGWORM.—Dr. Foulis considers the following an effectual plan of treatment in ringworm of the scalp (*British Medical Journal*, March 14, p. 536). The affected child, the hair being cut short over and around the affected parts, is seated before a basin half filled with warm water, and a folded towel tied round the forehead, so that no fluid poured on the head can trickle into the eyes. The child bends forward over the basin, and spirit of turpentine is freely poured



over one or more spots at a time, and well rubbed into the scalp with the forefinger. This removes dirt and greasy scabs, and the short broken hairs are seen to stand up like bristle. In about three minutes smarting is complained of, showing that the turpentine has penetrated deeply. Carbolic soap is then immediately well rubbed in and made to lather by the warm water, the smarting soon subsides, and the head being now beautifully clean, is dried. Compound tincture of iron, in two or three coats, is now painted well over the affected parts and allowed to dry. Carbolic oil (1 in 20) is then rubbed into the rest of the hair when it is dry. This treatment, applied every morning, or morning and night in severe cases, generally cures the worst cases in the course of the week. (It is this method which has been found unsuccessful by Dr. Hallopeau and Laller in Paris. See *Journal of Cutaneous and Venereal Diseases*, February p. 50. Dr. Foulis' name is misprinted 'Fontis.') Dr. Henry Browne (*British Medical Journal*, June 6, 1885, p. 1, 153) gives the following formula as having yielding perfectly satisfactory results. R. Sodæ hyposulphitis 3 i., solve in aquæ fl. 3 viij., et adde acidi hydrochlorici fl. 3 i., for outward use only. The lotion is applied on lint covered with oiled silk, and accompanied by daily washing of the scalp with soft soap and water. Dr. A. I. Harrison communicated a paper on "A New Method of Treating Tinea Tonsurans" to the section of medicine at the last meeting of the British Medical Association (*British Medical Journal* September 5, 1885), and published a note giving further explanations (*British Medical Journal*, December 5, 1885, p. 1, 059). This treatment, as finally modified, consists in the application by dabbing on the scalp, of a solution of a half a drachm of iodide of potassium to the ounce of a mixture of equal parts of liquor potassæ and spirits of wine, for three or four minutes at a time. When this has been done two or three times at intervals of two or three days, a solution of four grains of bichloride of mercury to the ounce of a mixture of equal parts of distilled water and spirit

of wine is applied in the same manner, and on the first occasion ten minutes after the use of the potash and iodide lotion, afterwards it is used by itself two or three times at two days' interval. A few days are then allowed to elapse without the application of any remedy, and then the potash solution is applied once, and followed up with the mercurial solution at an interval of ten minutes. Dr. Harrison has treated many cases in this way with good results, and claims great penetration for the remedy, as the hairs are much softened by the potash, while the mercury is precipitated *in situ* by the iodide of potassium, and thus brought into immediate contact with the fungus in the hair-follicles.—*Journal of Cutaneous and Venereal Diseases*.

**TREATMENT OF PIGMENT SPOTS OF THE SKIN.**—According to Unna, borax and the bichloride of mercury are the medicaments most generally employed for the removal of pigment spots; the first is slow and mild in its action, rarely occasioning eczema; the second acts more energetically and rapidly.

If we desire to have the speediest possible effect, it is necessary to have recourse to mercury, not in the form prescribed by Hebra, which is inconvenient, but a solution of the sublimate in collodion (one-half to one part). The danger will thus be avoided of provoking redness, desquamation, and sometimes even a bullous eruption.

These energetic treatments have one inconvenience: we cannot exactly measure the effect. On this account, it is preferable to employ the mercury and bismuth ointment proposed by Hebra. A piece of muslin coated with the ointment will enable us to obtain a more prompt effect than with feeble solutions, besides being much more convenient of application.

Small pieces of muslin, about the dimensions of the groups of freckles or chloasmic spots, should be smeared with ointment, and after first removing the greasy matter from the surface with cologne or alcohol, they should be applied to the affected parts. The application should be made upon the patient retir-

ing at night, and washed off the next morning. Bandaging or collodion is unnecessary.

The author prescribes for use during the day a bismuth ointment, which has the advantage of masking the brown spots.

The following is the formula of the ointment :

R Oxide of Bismuth,  
Kaolin  $\bar{a}\bar{a}$  5 grams.  
Vaseline 20-40 "

M.

The ointment should be applied only to the pigmented spots, allowed to dry and not be removed for sometime.

He also employs the following formula :

R Oxide of Bismuth,  
Rice Powder  $\bar{a}\bar{a}$  2 grams.  
Ung. Glycerinæ 10 "  
Eau de Rose 20 gutt.

M.

By alternating the mercurial and bismuth applications, the pigment patches rapidly disappear without redness or desquamation, if the pigment be not so deeply situated in the derma that the remedies cannot reach it without destroying the papillary layer, as is the case in certain chronic chloasmas.

The following is Hebra's formula:

R Subnitrate of Bismuth,  
White Precipitate  $\bar{a}\bar{a}$  2 grams  
Lard - 50 grams.

M.

To be spread upon a piece of lint, and applied during the night to the pigmented patch.

Kaposi employs the following ointment in the same manner.

R Salicylic Acid 2 grams.  
Emollient Ointment 40 "

M.

Or,

R Boracic Acid,  
White Wax  $\bar{a}\bar{a}$  5 grams.  
Paraffin 10 "  
Oil of Almonds 30 "

M.

Frictions with the ordinary mercurial ointment sometimes succeed well—*Jour. de Méd. de Paris*, No. XV., 1886.—*Journal of Cutaneous and Venereal Diseases*, July, 1886.

#### TREATMENT OF VESICAL CALCULI.—

Dr. N. P. Dandridge, in a paper read before the Ohio State Medical Society, in June, 1886, thus formulates his experience in the treatment of stone.

Every case demands

1. An examination of the urethra, to determine its calibre and its tolerance of instruments.

2. A careful estimate of the size and composition of the stone.

3. A careful examination of the urine, to determine the character of the stone and the presence of Bright's disease or diabetes.

The present aspect of the treatment of vesical calculi justifies, in his opinion, the following conclusions:

1. In children, all cases should be submitted to lateral lithotomy, except in the very rare cases where the size of the stone demands the high operation.

2. In adult cases rapid lithotripsy should be the rule, and is capable of dealing with about nine-tenths of all the cases met with.

3. Stones of unusual size, from one and one-half ounces upwards, should be submitted to suprapubic lithotomy.

4. Stones formed round a foreign body can be safely removed by median lithotomy, even when of large size.

5. Stricture, simple and uncomplicated, should be first relieved by dilatation or internal urethrotomy, and the stone subsequently crushed.

6. Stricture, when indurated, or complicated by fistula or marked cystitis, should be submitted to a perineal lithotomy, and, by preference, the median operation should be chosen.

7. In hypertrophy of the prostate, the question of operation is to be largely determined by the necessity for drainage of the bladder.

8. The same can be said of the influence of cystitis in deciding upon the choice of operation.

9. In case of uncertain diagnosis, the median operation is indicated in order to permit of digital exploration of the bladder cavity.—*The Cincinnati Lancet and Clinic*, June 5, 1886.



"CAN IMAGINATION KILL?"—This is, perhaps, hardly the correct form of question the *British and Colonial Druggist* puts to itself in discussing the death of the young woman at Hackney under circumstances in which Keating's insect powder largely figured. As the powder appears by Dr. Tidy's experiments to be perfectly harmless the suggestion is not unnaturally made that the deceased, who was possibly of a hysterical, highly imaginative turn of mind, took the powder in the full belief that by its means her death might be accomplished? The writer of the article in our contemporary, we think wrongly, brings forward two remarkable instances of what may be regarded as practical jokes with melancholy terminations. In the case of the convict delivered up to the scientist for the purpose of a psychological experiment (the man was strapped to a table and blindfolded, ostensibly to be bled to death; a syphon containing water was placed near his head, and the fluid was allowed to trickle audibly into a vessel below it, at the same that a trifling scratch with a needle was inflicted on the culprit's neck; it is said that death occurred at the end of six minutes) fear must have played no inconsiderable share in the fatal result, and we do not know whether all the vital organs were in a sound condition, though they were presumably so. The old story of the case of a college porter is also one in point. The students entrapped him into a room at night, a mock inquiry was held, and the punishment of death by decapitation decreed for his want of consideration to the students. It is small wonder that, under the dominion of fear and belief in the earnestness of his tormentors, the sight of an ax and block, with the subsequent blindfolding and necessary genuflexion, a smart wrap with a wet towel on the back of his neck should have been followed by the picking up of a corpse.—*Lancet*, July 10th, 1886.

AN ANODYNE FOR USE IN VESICAL IRRITATION.—Dr. W. P. Copeland, of Eufaula, Ala., writes to the *Med. Record*: "In most every community there are old men who suffer from enlarged prostates,

accompanied with chronic inflammation of the neck of the bladder, rendering them miserable sufferers and a care and anxiety to their friends and families. Having had the professional care of several of this class of cases, and dreading the tendency they so frequently incur by the administration of opium for the relief of pain, I resorted to various washes for injecting the bladder, resulting in my adopting a solution of benzoate of soda, ten grains to one ounce of water, with twenty to thirty drops of the green tincture of gelsemium; this is warmed and injected by the patient through a soft-rubber catheter, whenever the pain is severe, and the catheter withdrawn, leaving the medicine to be voided in twenty to thirty minutes; or where they are not able to pass anything from the bladder, the catheter is reintroduced and the medicine allowed to escape. My experience with this treatment has been so satisfactory that I cannot refrain from giving it publicity to the profession."

CONSTIPATION IN INFANTS is thus discussed by various contributors to recent numbers of the *British Medical Journal*:

Dr. W. R. Cossham has generally found much benefit from ordering the infant to be fed every morning with a cupful of gruel, which may be sweetened with a treacle of honey. Further help is obtained by giving a teaspoonful of cod-liver oil twice a day, and using friction over the bowels every night with olive oil on the palm of the hand. An occasional morning draught may also be necessary, such as tinc. podoph.  $\mathfrak{m}$ ij (gr. ij ad 3j); pulv. ipec. gr.  $\frac{1}{2}$ ; glycerini 3j; aquam anisi ad  $\mathfrak{z}$  ss.

L. suggests two or three meals of "Mellin's food," daily. He has found this useful, and has long since dispensed with drugs as much as possible in the treatment of some troublesome cases. If the infant is being nursed, two or three meals a day will be sufficient, and these may be dispensed with as soon as the object is attained, and resumed if necessary; but if it be living upon artificial food, "Mellin's food" should be substituted.

Mr. E. Gibson Berkley says that the liquid extract of cascara sagrada, combined with minute doses of tincture of nux vomica, and made palatable with a little syrup of lemon or glycerine, will be found very useful. It should be given two or three times a day.

Sign-post recommends feeding the infants on well-made oatmeal gruel and milk, in proper quantities, and at intervals. For an infant from four to six months old, he advises half the feeding-bottleful of milk, with the same quantity of oatmeal gruel, to be given every four hours. The directions for preparing the gruel are as follows: Take a teaspoonful of the common coarse, but sweet (not bitter), oatmeal; let this soak in a little more than a tumblerful and a half of cold water for some hours, say all night; then place this meal, and the water, in a clean covered saucepan capable of holding double the quantity of the liquid poured in; place the saucepan near the fire, so as to heat the contents slowly, and after a time place it on the fire, and stir the contents, until, and for a minute or so after, it boils; then pour the contents on to a horsehair sieve; the creamy gruel is made.

Mr. M. F. Bush advises a spill of paper dipped in castor oil about two or three inches, and inserted into the bowel. It should be used every day for a time.—*Med News.*

**EFFECT OF MENTAL OVERWORK UPON THE TEETH.**—Among the hard-worked pupils of the Paris public schools, the teeth become deteriorated in a few weeks after entry. The second dentition is often premature. These observations confirm the statements of Dr. J. L. Williams, who has given attention to this subject. He has shown that any mental strain shows itself upon the teeth in a short time, both in increased decay, as well as in increased sensibility of the dentine. Dr. D. M. Parker has reported that these same changes are always apparent in men who are training for athletic trials. As there is not the slightest doubt of the accuracy of these observations, they show that these are matters which demand serious consid-

eration from educators.—*Boston Med. and Surg. Journ.*

**TOXIC EFFECTS OF CORROSIVE SUBLIMATE USED AS AN ANTISEPTIC.**—This substance has come into very general use during the last few years, in the form of a solution as an antiseptic. There can be no doubt that it possesses very considerable antiseptic powers; but unfortunately, it is also a violent poison, and abundance of cases are now on record which show that its use is often attended with very great risk of toxic effects resulting from its absorption. In a paper recently contributed by Dr. Lucien Butte to the *Nouvelles Archives d'Obstétrique et de Gynécologie*, a long series of such cases are adduced, in many of which a fatal result followed persistent vaginal injections of the solution of Van Swieten (1 in 1000). The symptoms of poisoning were the more difficult to detect from the fact that, occurring during the puerperal period, they were masked, to some extent, by those incidental to this state. They consist principally of hypogastric pain and tenderness, violent abdominal pain of colicky character, accompanied by frequent mucous stools, often stained with blood. The urine is generally diminished in quantity, and contains epithelial cells, casts, and more or less albumen. Salivation is most frequently absent, but the mouth and throat are red and dry, and there is marked thirst. Dr. Butte is inclined to consider that absorption occurs most frequently in cases where lacerations of the perineum, or of the cervix uteri, have taken place, or where large ulcerating surfaces are present. The toxic effects are naturally more marked in debilitated and cachectic patients. The post-mortem appearances are indicative of enteritis, with sloughing of the mucous membrane of the large intestine, while the kidneys are enlarged and anæmic. Deposits of crystals of oxalate of lime are common in the uriniferous tubes, due, it is suggested, to the decalcification of the bones, which is said to result from the presence of the bichloride in the system. As Dr. Butte quotes no fewer than twenty cases, in which the



fatal result was attributed to absorption of the mercury, it is evident that, in obstetric practice at any rate, the use of even extremely diluted solutions requires very great caution.—*Brit. Med. Journ.*, June 19, 1886.

VANDERBILT AND THE YOUNG DOCTOR.—The following anecdote has been published in one of the New York papers: A young physician of that city, who had been struggling along in rather an uneasy fashion, was suddenly elated one day, a year or so ago, by a call from Wm. H. Vanderbilt. The young doctor had been a close student, and had won laurels at one of the city hospitals for his surgical work; and in the course of conversation at the Grand Central Depot Mr. Vanderbilt heard the young man's praises, and acting upon a sudden impulse, as was not unusual with him, he went directly from his office down to the doctor's office. He had been suffering for some time from a trouble that many physicians of high repute had treated unsatisfactorily, and now, for the whim's sake, he put himself under the young doctor's care. He was cured quickly, and became an enthusiastic advocate of the young doctor's skill. Many of his friends were sent to the same office, and to-day a big practice, including patients known in the most fashionable circles of New York, enriches the lucky physician whose prospects had been woefully gloomy till the whim of the magnate rescued him from obscurity. But this isn't the point of the story. After it became known that he had treated Mr. Vanderbilt, his friends crowded around to explain how he might grow rich. Mr. Vanderbilt was grateful for the cure that had been effected, and all that Dr. X. would have to do, so the acquaintances whispered, was to ask the railroad ruler for a point on the stock market, and through the use of that scoop in a smart little fortune. It was certainly a temptation, for Mr. Vanderbilt had not been backward in his expressions of gratitude. But before he acted on any of these suggestions, he saw Mr. J. Rhinelander Dillion, his personal friend as well as a patient, and asked his ad-

vice. "Send in your regular bill," was Mr. Dillion's counsel. "Don't make it one cent bigger than you would to a poor man. Vanderbilt's generous, but he never lets anybody impose upon him. Send in your regular bill; if you try anything else, you'll hurt yourself." The doctor acted on this advice. The bill he rendered was for \$50. The check that the next mail brought him was for \$1,000.—*New England Med. Monthly.*

TREATMENT OF GONORRHOEA.—From a lecture recently given by Dr. Hearn, the following was taken regarding the treatment of gonorrhœa:—

For the first stages, a mild diet, avoid excesses, especially of drink; locally, hot-water baths for penis, also hot-water injections, together with the antimonial saline mixture, or—

R<sub>x</sub>. Potas. citrat., gr. xx  
Sodii bromid., gr. xl. M.  
Sig.—Ter die.

In second stage, resort to copaiba, cubebs, and especially was oil of sandalwood recommended. Copaiba could be given in a mixture of acacia syrup and water, together with citrate of potassium, or in syr. sarsaparillæ with cubebs.

In third stage, use one of the following as injections:—

R<sub>x</sub>. Plumbi acet., gr. ij  
Zinci sulph., gr. j  
Aquæ, fʒj. M  
Sig.—As injection.

R<sub>x</sub>. Hydrarg. chlor. corros., gr. j  
Liq. calcis, fʒj  
Aquæ, fʒ xij. M.  
Sig.—As injection.

If discharge persists, use steel bougies three times a week.—*Col. and Clin. Record.*

AN EXCURSION OF MEDICAL MEN TO PEN-MAR AND MONTEREY SPRINGS, W. M. R. R.—Through the courtesy of the President of the Western Maryland R. R. and the Proprietors of Monterey Springs Hotel a large number of physicians from this city were permitted to enjoy a most pleasant excursion to the

Blue Ridge Mountains in this State on Tuesday of the present week. A special excursion train with some 90 physicians left the city at 9 A. M., and after a charming day on the mountains were safely returned at 8.30 P. M. The object of the excursion was to acquaint the medical profession, of this city, with the superior advantages of the Blue Ridge Summit as a health resort, and with its accessibility to the city. The Monterey Springs Improvement Company has expended a large sum of money in erecting hotel buildings and cottages for the accommodation of guests. All improvements have been made on the latest plans, special reference being had to drainage and sanitation. It is the design of the Improvement Company to make this section of the State the great Health Resort for our city, and such work as has been done is thorough and in keeping with this idea.

It would be difficult, we think, to find any section of the State more admirably situated and adapted to all the purposes of a Health Resort than the one selected by the Improvement Company. Its elevated position on the summit of the Blue Ridge, the beauty of its natural surroundings, the purity of its atmosphere, and its easy access to our city make the location all that is to be desired. The gentlemen interested in the development of this region include such well-known names as Mr. Francis T. King, Dr. Jas. Carey Thomas, Mr. John Curlett, and President Hood of the Western Maryland R. R., which names, we think, are a sufficient guarantee of the success of any undertaking looking to the health or comfort of the public.

After a bountiful dinner served by the Proprietors of the Monterey Springs Hotel the excursion party was driven to Pen-Mar. High Rock, Brinkwood, Ragged Edge and Mt. Quirauk, from which elevated positions views of the surrounding country were obtained. The enjoyment of the excursion party was most marked. All who participated were warm in their appreciation of the courtesies extended by the Western Maryland Railroad Company, and the Proprietors of the Monterey Springs Hotel.

## Medical Items.

Dr. Brown-Séguard has at last been elected a member of the Paris Academy of Sciences. His competitors included such men as Bouchard, Germain-Sée, Jaccoud, Hayem and Ricket.

The attempt in this city to inoculate a boy who had been bitten by a rabid dog, with the preventive virus, has, it is said, been given up. Several inoculations were made by Dr. V. Mott, but the boy began to show such severe nervous symptoms that it was thought wise to discontinue the treatment.—*Medical Record*, July 17, 1886.

The exodus of American physicians to Europe during the present summer is very large. No less than fourteen physicians sailed from the port of New York last week. Among this number were Drs. F. Donaldson and H. P. C. Wilson, of this city, Dr. J. S. Billings, of Washington, Drs. Barker, Lusk, Shaffer, and others, of New York, and Dr. Chadwick, of Boston.

*Progress* is the title of a new monthly medical journal, edited by Dr. Dudley S. Reynolds, of Louisville, Ky., an experienced and well-known journalist. The first number, now on our table, is well-filled with original matter, and is handsomely gotten up in appearance and arrangement. We wish the new enterprise abundant success.

The daily reports by cable of the cholera epidemic in Southern Europe show a slight increase in the number of cases and an increasing mortality. The disease is expending its force in the small cities and towns along the shores of the Mediterranean in Italy and Spain. As the summer is now about half gone the prospects of a violent outbreak are daily diminishing. We may hope to escape the disease in our country the present year.

The following is a formula given by Dr. Levis, much used at the Pennsylvania Hospital for *fixed dressings* :

R. Glue, - - - lb 1  
Oxide of zinc, - - - lb 2  
Water, - - - Cong. 1. M.

Sig.—To be applied while hot, by means of a brush.

It takes only a few hours to harden, in this respect being preferable to the silicate of soda dressing.—*Col. and Clin. Record*.

Dr. Jurist recommends the following in various conditions of the *throat* requiring a gargle :

R. Tinct. guaiac. comp., aa f3ij  
Tinct. cinchon. comp. f3j  
Potas. chlor.. f3j  
Mel desp., f3j  
Aqua, q. s. ad f3iij. M.

Sig.—As a gargle.—*Col. and Clin. Record*.



Original Articles.

UTERINE FIBROIDS TREATED  
BY THE FLUID EXTRACT  
OF ERGOT.\*

BY CHARLES T. PARKES, M.D., OF CHICAGO.

My intention is to relate to you the history of four cases of uterine tumor, and to present a few remarks suggested by them. These four cases were treated by the internal administration of Squibb's fluid extract of ergot. They all resulted in recovery by expulsion of the growth.

I found no insurmountable difficulty in giving the medicine, although when given for a prolonged period it creates nausea and disgust in some. This was counteracted, and the pain following its use controlled by combining it with morphine. It seemed to me preferable to the hypodermic use—the latter being locally painful and often producing abscess, besides it is not followed by any better result. Two of the cases, treated by ergot, when thrown off, proved to be pure uterine fibroma—dense and hard—white and glistening when cut open—consisting of simple fibrous tissue. The other two following the action of ergot were soft myomata—pultaceous and semi-elastic—consisting mostly of connective tissue, confirming the diagnosis made. All four of these were evidently sub-mucous tumors, or so slightly interstitial as to be practically covered only by mucous membrane.

CASE I.—Mrs. S., American, 43 years old, widow, three children, no miscarriages, menstruated first when 16 years old. Never had any noticeable trouble with menstruation until three years previous to my first examination; during these years she had suffered with irregular profuse hæmorrhages which were now continuous, accompanied with exacerbations on the slightest exertion. My first examination was made February 20th, 1876. As my memory brings this patient before me she presented the most perfect example of transparent flesh that

I had ever seen. A large, finely formed woman, her flesh looked like alabaster, apparently destitute of blood. The legs were oedematous, the heart beat feeble and rapid, and the slightest exertion was followed by extreme palpitation and the most fearful feelings of suffocation. Her answer to what she had done for her trouble was that she had taken "quarts of medicine." Vaginal examination revealed an enlarged uterus and patulous os, from which blood was rather freely oozing. The sound entered the uterus about five inches, the handle being deviated forwards and to the left side. A diagnosis of submucous uterine fibroid was made.

The treatment adopted was the administration of strychnia and iron, together with wine and good diet for the general condition, and one-half drachm doses of Squibb's fluid extract of ergot every six hours, to either expel or kill the growth. Locally, to stay the hæmorrhage, a small tampon of pulverized alum was applied to the *os uteri* and held in position by ordinary cotton tampons.

The first forty-eight hours' use of the ergot produced quite severe uterine pains, so acute that the patient in her weakened condition said they were unbearable. At this visit Dr. T. D. Fitch was with me in consultation. The tampon of alum was removed, and Dr. Fitch's examination confirmed the diagnosis made, and advised the continuation of the treatment. As the bleeding had been entirely controlled by the tamponade, it was left out. The ergot was continued as before, and a sufficient dosage of morphine ordered, to make the pains bearable if they persisted. No further use of the tampon was required, the uterine contractions never ceased while the ergot was administered. On the sixth day of its use a foul-smelling serous discharge came on *per vaginam*, accompanied with slight general chilliness and a temperature of 102° F. The patient was assured that the tumor was surely coming away, and encouraged to bear "yet awhile" with her great suffering. On the eighth day the tumor was found in the vagina and removed. It

\*Read before the Chicago Gynæcological Society, May 23, 1886.

was about the size of a duck's egg and very hard to the touch. After a short period of mild septic trouble the patient passed through a quick convalescence and rapidly recovered. Save a few months ago she says she has never had any illness since getting rid of this growth, and certainly looks well.

CASE II.—Mrs. P., German, married, five children, no miscarriages, menstruation began at 14, now 37 years old. Seen by myself first in March, 1881. The patient is a robust, hearty woman. Never had any trouble until six months after the birth of her last child, about one year ago, when she began to flow too freely and too often—as often as every week or occasionally twice a week. The blood was in large quantity and bright red in color.

The examination revealed an enlarged uterus—it could be felt above the pubis during bimanual examination. The sound entered easily for five inches, the handle deviating forward and to the left. Its use was accompanied and followed by very free bleeding.

*Diagnosis.*—Submucous uterine fibroid on anterior wall. *Treatment.*—Locally the alum tampon was used as in the previous case. Squibb's fluid extract of ergot in half drachm doses every six hours. The patient was ordered to remain in bed. On the succeeding day all the tampon, except the alum, was removed. No hæmorrhage; slight pains complained of. On the second day the pains were very severe and morphine was given to control them. The alum tampon was removed and a carbolized hot water injection ordered three times a day. On the third day pains still severe and a foul-smelling vaginal discharge commencing.

This condition persisted until during the night of the eighth day, when I was summoned to the patient on account of the unusual severity of her sufferings, the messenger, her husband, saying it was just as if she was having a baby. On my arrival the pains had quite ceased. Examination showed the loss of considerable blood, and the vagina was found filled with a large fleshy mass, horribly offensive. The finger could be passed

beyond it, and the largely opened cervix recognized. It was seized with a Vulsellum forceps, twisted a few times upon itself, and then delivered. The mass was as large as a closed fist, dark colored and ragged all over its surface and very foul smelling. The patient rapidly regained her usual health, and is well to-day.

CASE III.—Mrs. E., 33 years old, married, three children living, one miscarriage, menstruation commenced when 14 years of age. Was first called to visit her January 2, 1885, for severe uterine hæmorrhage. She then informed me that she had never had trouble with menstruation until about two years previous.

Shortly thereafter she was operated upon for laceration of the cervix, without much relief to her trouble, since she had gradually grown worse, so that she was not free from bleeding ten days in the month.

One year previous to my seeing her, the uterus was freely curetted and fuming nitric acid applied to the cavity as a relief for the bleeding. The procedure failed in any good result.

At this visit the bleeding was extreme in degree. Examination revealed the pelvis largely filled with a smooth, doughy mass. After considerable searching the *os uteri* was found high up above and close to the pubis. It could only be found by crowding the finger between the bone and the growth. The growth was exquisitely tender to the touch or any manipulation. Bimanual palpation discovered an uncertain mass above the pubis. The vagina was tamponed temporarily, and morphine administered hypodermically. The diagnosis was reserved. In my mind it rested between hæmatocele and soft myoma. The tumor was compressible, at least its elements seemed to give way to the pressure of the finger; it was semi-elastic and painful under manipulation, filled the entire posterior half of the pelvis, and the *os* was carried well upward and forward. It might be, and probably was, a myoma of the posterior uterine wall retroverted.

A few weeks ago I had the satisfaction



of seeing a *fac simile* of this case, so far as the character of displacement and the position of the tumor was concerned, in a patient under the care of Dr. Merriman, although the tumor in Dr. Merriman's case was much harder and more resistant.

Dr. Merriman, with skill and apparently with ease, lifted the tumor out of the pelvis into the general abdominal cavity, after placing the woman in the knee-elbow position—a change bringing much comfort to the patient. I learn that under the use of ergot the growth is already diminishing in size.

The patient was put upon fluid extract of ergot in one-half drachm doses three times a day. The next menstrual period showed no change other than a diminished loss of blood. In June the flooding was quite free and accompanied with considerable pain. In July everything was as bad as possible, with so much pain that the ergot was discontinued. Repeated examination now narrowed the diagnosis down to soft myoma. The removal of the uterine appendages was suggested, in hope that this procedure would anticipate the menopause, stop the bleeding and lead to the gradual atrophy of the growth. In September, consultation was solicited with Dr. W. H. Byford, when the patient was etherized and carefully examined. The sound, introduced with great difficulty, owing to the displaced position of the os, passed in over five inches, positively demonstrating the nature of the growth, its consistency showing it to be the soft variety of myoma.

As the patient could not be said to be in absolute danger of her life, the operation was refused by her friends, although the sufferer was willing enough to have it done.

The previous treatment was endorsed by Dr. Byford, and its continuance advised.

The fluid extract of ergot was resumed and rendered bearable by morphine.

The October illness was accompanied by slight hæmorrhage, but excessive pain. These uterine contractions continued on after the menstruation

ceased, until, during the last week of October, they became labor-like in character. Examination now revealed that the uterus had righted itself, the os was becoming patulous and its edges thinned out; through its opening the projecting tumor could be felt. On the 2d day of November, pieces of the broken-down mass, horribly offensive, could be seized with the forceps, pulled out of the uterus and cut away.

Chilly sensations began to be felt by the patient, sweatings came on, the temperature ran up to 101° F., and a mild septicæmia was established. During the following week the pains never ceased. Quinia was administered freely. The vagina and uterus were irrigated with hot carbolized injections, and the mass removed as fast as any of it could be reached, and at the week's end the last remnant was gotten away. The patient was very much reduced physically, but rapidly convalesced, and is now perfectly well, with her menstruation normally re-established. Fully a quart of soft pulqueous pieces of the growth were removed.

CASE IV.—Mrs. L., German, 34 years old, one child, was seen first November, 1885. She had been suffering with increased menstrual flow for a year. She came to me to be treated for an external painful, labial swelling. It proved to be a vulvo-vaginal abscess. It was opened freely and gave no further trouble. A uterine tumor was noticed and examined. It was found to be of considerable size,—could be detected above the pubis.

She was put upon one-half drachm doses of fluid extract of ergot every six hours.

This she continued for six months steadily, with varying conditions of pain and hæmorrhage, until in April, 1886, the hæmorrhage ceased, pain became very severe, and a shreddy, foul-smelling discharge manifested itself. She was removed to the St. Joseph's Hospital, and after ten days of antiseptic washings and removal of masses of broken-down tissue, the mass was entirely extruded. This patient had also quite a severe septicæmia, but finally recovered and is now well.

*Remarks:*—Aside from crucial demonstration, it seems reasonable to assert that these four cases were cured by means of the remedy used, and by that alone. It is well known that the most of authorities state that no positive reliance can be placed on the use of ergot. My experience surely, as here illustrated and confirmed by other cases seen, leads me to think that this adverse judgment must be qualified, especially in the treatment of the sub-mucous bleeding fibroids of the uterus. If the growths be partially interstitial, the less the thickness of uterine tissue between them and the mucous covering, the more certain will the remedy be curative. Of course it will be impossible to demonstrate the exact amount of uterine wall forced contractions will destroy, hence a trial of its worth is desirable in all cases not purely sub-peritoneal and pedunculated. Still I am quite convinced the severity of the hæmorrhage gives one a good reason to speak *positively* of the results to be accomplished by its use. I have not deemed it necessary to look up the history of the first use of this remedy for stimulating uterine contractions. It is sufficient for me to say that my confidence in the remedy and persistence in its use, even when failure of good results seemed certain, has followed directly as the result of the teachings and experience of an honored Fellow of this Society, Dr. Wm. H. Byford, who has never lost an opportunity to urge upon the profession his belief in the specific action of the remedy, and its absolute certainty of cure in many cases. I am quite sure that Dr. Byford deserves the credit of being the first to make use of ergot with the idea of destroying the vitality of the growth, and as well, causing its expulsion from the uterus.

The third case shows plainly how absolutely unnecessary any operation would have been. The removal of the appendages might have stopped the hæmorrhage, but such a perfect cure as now exists could never have followed operation, to say nothing of the harm done by unsexing the woman; still no case could present better reasons for such a procedure, none in which it would have been more justi-

fiable from the indications present. To me it brings the lesson to make oöphorectomy the *dernier ressort* in all cases, certainly to give the remedy used at least a six months' trial without result before operation be sanctioned.

The difficulties attending the differentiation between a sack of fluid and the soft myomata was well illustrated by this case. The sensation communicated to the touch was scarcely distinguishable from fluctuation. It was only after repeated examination under ether, and the use of the sound, that the diagnosis was satisfactorily settled.

The fourth case for a time seemed one in which the treatment would come to nothing. Every one became discouraged. The suffering was increased, and no advance was made, apparently. By persistence the cure was accomplished. In this case operative interference was solicited by the patient, and would have been most readily submitted to, without any urging. If I read aright the indications which authorities give, to justify the resort to removal of the uterine appendages, they were all present in this case, and more too if that were needed. Certainly the final result has proven any such interference would have been uncalled for and lamentable.

I am quite well aware that four cases cannot be considered absolutely demonstrative of any rule, still these four increase the number already published in proof of the curative action of ergot, administered thoroughly, for sub-mucous uterine growths. It is impossible for me to understand how some good authorities can still assert their disbelief in ergot; in fact, calling it the most inert and disappointing of all drugs. No possible argument can disabuse my mind of the belief that its action was positive and certain in the cases related. No law has as yet been evolved fixing even by approximation the period of time required for the effects of the medicine to show themselves. The idiosyncrasies of the patient, the thickness of the uterine envelope, the distance from the mucous membrane, the purity of the drug, and many other conditions, render it scarcely possible that any such law can ever be



laid down. The trial should be made patiently and persistently, just so long as the patient's condition will warrant its continuance, and a complete expulsion of the growth, followed by rapid recovery, will be the reward.

## OCCLUSION OF THE OS UTERI AS AN IMPEDIMENT TO LABOR, WITH A REPORT OF TWO CASES.\*

BY F. E. WAXHAM, M.D., OF CHICAGO.

Having met with occlusion of the os but once in several hundred cases of labor, and knowing of a number of physicians of extensive practice who have never seen this condition present at the time of confinement, I am convinced that it must be of rare occurrence, and the history of two cases may not be uninteresting.

Mrs. S., primipara, twenty-nine years old, German, fell in labor about 9 P. M., February 21, 1885. The membranes ruptured soon after the commencement of labor and the amniotic fluid gradually drained away.

The patient was seen between 3 and 4 A. M., at which time pains had become very severe and frequent. Upon examination the head was found low down in the inferior strait, almost presenting at the vulva, and covered apparently by a thin membrane through which the advancing head threatened to burst with every pain. Upon the most careful digital examination, no os could be discovered nor the slightest indication of one. Dr. Nelson was summoned and promptly responded. His more experienced finger detected a very slight dimple in the center of the presenting tissues. By keeping the finger upon this slightly thickened tissue, he discovered that it became very much thinner with every pain, while as the pain subsided the tissues assumed a very slightly umbilicated appearance. By firm and continued pressure upon the suspicious spot an

opening was at length effected and the os gradually dilated. As the labor proceeded slowly, and fearing the result to the child of so long a delay of the head in the pelvis, and the os being fully dilated, the forceps were applied. The child was delivered without injury to the mother, but it was asphyxiated and required considerable effort in resuscitation. Dr. Nelson stated that this was the second that had ever come under his observation, and kindly gave me the history of the following one. He was called to attend a lady in her first confinement, a Swede, twenty-three years old, and married about one year. Making a hasty examination, he found a well-formed cervix but did not detect the os. On returning a few hours later, the head had descended to the inferior strait and was indeed presenting at the vulva and covered by the cervix, which had become so thin as to resemble the membranes. The membranes had already ruptured and the amniotic fluid had gradually escaped. There was no appearance whatever of the os. It could not be detected with the finger, and the head seemed about to burst through the uterine tissue. The patient was placed before a window, the labia separated and careful search made for the os. Only after most careful search was it found. It was patulous only to the extent of admitting the very finest surgeon's probe. After this had been introduced and worked about, a second probe was passed, and by separating them the os was gradually and sufficiently dilated to allow the finger to enter. The os was then rapidly dilated and labor progressed normally.

I find the literature on this subject quite meager, many of our writers on obstetrics omitting the subject entirely, while others refer to it very briefly.

Schroeder alludes to it in the following terms:

"As complete atresia of the os prevents conception, it follows that an occlusion of the os, observed in labor, must have taken place during pregnancy.

Very frequently there is a superficial and easily separable agglutination of the

\*Read before the Gynecological Society of Chicago, May 28, 1886.

external os. It is due to an inflammatory process of the lips of the os from a previous blennorrhœa. During labor the advancing head is seen to push the lower uterine segment forward to the outlet, and to thin it more and more. This thinning may be so great that the head appears to be covered only by the membranes. By an accurate examination the os feels like a small and soft dimple directed greatly backwards. If during a pain the finger or uterine sound be forcibly pressed against the dimple, the agglutination of the os will suddenly give way. The os itself now very rapidly dilates and labor proceeds without impediment. Often the pains themselves succeed in breaking down the adhesions of the os.

It very rarely happens that the os only partially dilates after the agglutination has been torn through and remains rigid so as later to require incisions. There is very seldom so firm an adhesion between the maternal and foetal membranes in the immediate vicinity of the internal os that the lower uterine segment cannot retract over the ovum. Separation by the finger or rupture of the membranes renders possible the dilation of the os."

Schroeder also refers to the fact that a firm cicatricial band may occasionally occlude the os, resulting from inflammation of the cervix or cauterization:

When these firm adhesive bands prevent dilation of the os there is danger of rupture of the vault of the vagina unless incisions are made and assistance given. The cicatricial closure of the os is frequently incomplete; more or less fine openings remaining pervious, rendering conception difficult but still possible, is believed by Schroeder to frequently result from ulcerative inflammation during the lying-in state.

Leishman, in discussing the subject, remarks that

"There are some cases in which there seems to be actual occlusion of the os. Impregnation in the case of an occluded os is as impossible as that the normal function of menstruation should be carried on, and therefore we must assume, in such cases, that the closure must have

taken place subsequently to the entrance of the seminal fluid. It is of course possible that the os may remain open to a very limited extent, and yet the state of the tissues renders distention impossible, so as practically to constitute an impediment as insurmountable as actual occlusion would be."

Playfair gives the following brief intimation of this condition:

"Agglutination of the margins of the os uteri is occasionally met with and must of course have occurred only after conception. It is generally the result of some inflammatory affection of the cervix during the early months of pregnancy. Usually it is not associated with any rigidity or hardness, but the entire cervix is stretched over the presenting part and forms a smooth covering in which the os exists only as a small dimple and may be very difficult to detect at all. Occlusion of the os from inflammatory changes sometimes so alters the cervix that no sign of the original opening can be discovered."

All our authorities agree that the occlusion of the os is the result of inflammatory change occurring subsequent to impregnation. It is a noteworthy fact that in both these cases the membranes ruptured and the amniotic fluid escaped in the very early stages of labor, showing that the membranes were adherent to the uterine tissue about the internal os. As the internal os dilated, rupture of the adhesions and of the membranes necessarily followed.

### OPIUM TOXÆMIA IN A CHILD ONE MONTH OLD.—RE- COVERY.

BY A. L. HODGDON, M.D., OF FARMWELL, VA.

I was called in haste at about 4 P. M. to see a baby one month old which had developed alarming symptoms very suddenly. Upon arriving at the house I found the infant apparently moribund, pupils contracted, typical Cheyne-Stokes respiration, and in a deep stupor. I learned that the mother had given it the day before some pectoral drops, or soothing syrup, (it was hard to ascertain how



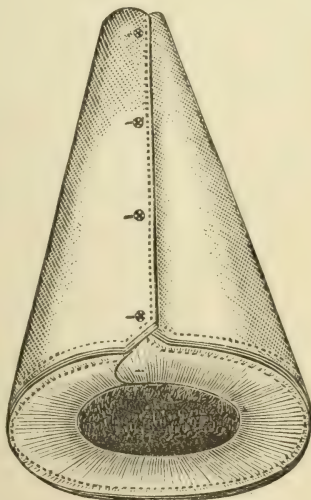
much) and had again repeated the dose in the morning, giving it a quantity about equal in strength to  $\frac{1}{2}$  of a grain of opium. Ordered at once a dose of ext. belladon. rad. fluid, and followed it up with an emetic of alum. Also gave an injection containing several teaspoonfuls of castor oil and a few drops of turpentine. It was not long before the pupils responded to the action of the belladonna, and the child seemed much better, and indulged in some calisthenic movements of the arms and legs. The emetic acted and a portion of the belladonna was ejected. I returned to my office with the provisor that they should let me know the condition of the child at 11 P. M. At which time the father came over with the intelligence that the babe was very low, that another physician (whom he called at the same time that I was sent for, and whose order to come had not been countermanded) was in attendance, and he (the father) wanted me to come at once, which I did, and found that the child's pupils showed a strong tendency to contract, that the doctor (then in attendance who had charge of the case until I could get there) had ordered coffee, another injection and hot baths as a means of stimulating the nerve centres. I continued the baths and administered another injection, as two or three teaspoonfuls of castor oil had been exhibited by the mouth according to my directions during the evening with no effect. In about 48 hours the child's condition, which improved temporarily, now began to assume a desperate character, the respiratory tract appeared to be clogged with mucus, and death seemed imminent. I ordered a handful of *good* tea, with water *quantum sufficit*, to be boiled down to one-half teacupful and strained, a teaspoonful of which was to be given every hour, until the child should manifest evidence of extreme wakefulness. An old lady, during the night, administered some alum in syrup, which, if it did not prove itself positively beneficial, certainly was fraught with no evil results. In the morning I found that the little patient had been awake for some time, it having taken about eight or ten

teaspoonfuls of the tea in as many hours, and the day following its condition was so good that I discontinued my visits, having been attending it from Sunday until Friday.

I am strongly convinced as to the value of the cautious use in infantile opium toxæmia of belladonna and tea, together with a primary emetic of alum, and subsequently one or more, if necessary, to clear the air passages of accumulated mucus, conjoined with a cathartic and injection if required. Another dose of belladonna was given during the stupor and finally the tea was brought into requisition with, I think, very good results. An interesting psychical study lay in the fact that the mother wished to exhibit some paregoric to the child, (already under the toxic influence of opium) with a view to quieting it when it became fretful and less somnolent.

### SPONGE-CONE FOR ETHER INHALATIONS.\*

BY RUSSELL MURDOCK, M.D., OF BALTO.



This cone is made of white rubber cloth, and when buttoned forms a cone, open at both ends.

The opening at the apex can be compressed to any desired extent. The

\*Exhibited at the American Ophthalmological Society, New London, Ct., July 23rd, 1886.

closed portion of the base interposes a dry surface between the wet sponge and the face, while the central opening confines the escape of vapor to a restricted region around the nose and mouth. The deep gutter, formed by the base and sides of the cone, will retain any surplus ether.

The cone can be had of Willms & Co., Baltimore and John Rynders, N. Y.

### Selected Articles.

#### THE TEST FOR ALBUMEN IN THE URINE.\*

In a Clinical Lecture delivered at the Philadelphia Hospital, Professor James Tyson, Physician to the Hospital, and Professor of General Pathology and Morbid Anatomy in the University of Pennsylvania, says: I shall to-day fulfill a promise made some time ago, to devote a lecture to a consideration of the test for albuminuria, with especial reference to certain more delicate tests recently proposed.

To begin, I shall first show you the ordinary heat test for albumen in a specimen of urine which contains a considerable quantity. It is a property of albumen to be thrown down by heat, provided the form in which it is present is neither acid albumen nor alkali albumin, which are respectively combinations of albumen with a small amount of acid and alkali. In this urine a precipitate follows the application of heat. As most of you know, phosphates are also thrown down by heat in a neutral or alkaline urine, but they are redissolved by a small quantity of any acid. Such addition does not, however, in this instance cause solution of the precipitate, and it is therefore albumen. A possible source of acid albumen is this—if it should happen that there is the least quantity of acid in the test tube to which albuminous urine is added, a combination takes place, and acid albumen is produced which is not precipitated by heat. While heat does not throw down acid albumen, nitric acid always does; and if

the test is applied in the way which I shall show you, it is not likely that any significant amount will be overlooked.

Now let me show you the defect of the ordinary method of testing. This urine is alkaline in reaction, and although it may contain considerable albumen, there will be no precipitate on the application of heat, for albumen is not precipitated from an alkaline solution unless there be a large amount present. I apply heat to this specimen of alkaline urine, and as you see, there is no change in its transparency. I add a few drops of acid and still there is no precipitate. We have, therefore, again a urine which is albuminous, but in which the application of heat and acid fails to show the presence of albumen. Let us not, however, conclude too hastily against the delicacy of the test. The quantity of albumen in a given specimen may be so small as to give no immediate response to heat and acid, when by waiting a little while the evidence will be plain. The quantity may be so small and the little flakes which are precipitated so fine, that they do not appreciably affect the transparency of the urine, and cannot, therefore, be at once recognized by the naked eye, but if time be allowed flakes to aggregate and fall to the bottom, they can be recognized in mass. In testing for such small quantities of albumen it is essential that the urine should be perfectly clear. Under ordinary circumstances, it will filter clear through one paper, or, if not then clear, the process may be repeated. But sometimes you find a urine that will not filter clear when thus treated. Under such circumstances, liquor potassæ or liquor sodæ may be added, the urine warmed and then filtered. The phosphates are thus precipitated in such shape that they can now be filtered out, and bacteria, which also contribute to the diminished transparency, are removed at the same time. If a perfectly clear urine, treated with heat and acid and set aside for six hours, is still perfectly clear, we may conclude that there is no albumen in it. But if a precipitate is found, does it necessarily follow that it is albumen? Not necessarily. It may be one of the three

\*From *The Polyclinic*, for July 1886.



things: nitrate of urea, which may be precipitated from a highly concentrated urine, acid urates, or albumen. But if the precipitate consists of nitrate of urea or acid urates, it will be redissolved on the application of heat. If it is albumen, on the other hand, the little flakes will again be diffused throughout the liquid, but they will not be dissolved. Used in this way, the test with heat and acid is much more delicate than is ordinarily supposed. This specimen of urine which we have just tried, and which immediately after the application of the heat and acid, was perfectly clear, is even now less transparent than it was a few minutes ago.

Another well-known test for albumen, which is sufficiently delicate for ordinary purposes, and one which is very useful in association with the heat acid test, is pure by Heller's or the contact method. Although this is commonly believed to be a very delicate test for albumen, it is not nearly as delicate as the heat and acid test. When used in connection with this test, it serves as an excellent control test for such albumins as although present in large amount, escape the heat and acid test on account of their combination with an acid or alkali. In applying this as well as the other contact tests for albumen, a short and narrow tube should be selected. If the tube is large, it takes longer to put in sufficient quantity of urine, and if it is long, the urine which is poured upon the acid acquires a momentum which causes it to bury itself in the acid. I place a convenient quantity of acid in the bottom, and carefully pour upon it a portion of the specimen of urine containing a small quantity of albumen, the presence of which was not immediately apparent by boiling and subsequent acidulation. There can now be seen at the junction of the two liquids a white line, which is precipitated albumen.

Are there any sources of error to be guarded against in using this test? There is at least one, based upon the fact when a urine is highly charged with acid urates, these will be precipitated when nitric acid is overlaid with it. This precipitate is, however, easily distinguished

from that due to albumen. The latter remains sharply defined between the urine above and the acid beneath, while the former rises in the course of a minute or two above the contact line. Again the acid urates are also readily dissipated by a gentle heat applied at the line of junction. More recently I have used almost exclusively instead of the nitric acid another reagent which is at least as delicate and more pleasant to manipulate. I refer to the acid salt or acid "brine" solution suggested by Dr. Roberts, of Manchester. This consists of a saturated solution of common salt to which five per cent. of hydrochloric has been added, and the whole filtered. Using some of the same urine, I first pour into the test tube some of the acid brine solution, and overlay it with the urine, and again you see a perfectly distinct white line. This test is valuable in association with the heat and acid test for the same purposes as the pure acid test. *Neither it nor the acid detect as small quantities of albumen as the heat and acid combined.*

During the past two years a number new test have been introduced, or rather a number of old tests have been revived by which much smaller quantities of albumen can be detected. Among them are the following:

Picric acid, the double salt of the potassium-iodide of mercury, picric acid with citric acid, sodium tungstate and citric acid, ferrocyanide of potassium.

As the last is the least delicate of these tests, I shall first speak of it. It is more delicate than the acid brine or the pure acid test, but not so delicate as the heat and acid tests used as I have suggested. It is applied by the contact method. It has this advantage over the other tests of this class, that it does not precipitate peptones. It does, however, according to Dr. Johnson, precipitate mucin.

One of the most delicate of these tests is picric acid. A saturated solution is employed, but as picric acid is very light it is not always easy to use the contact method, sometimes the picric solution will be lighter than the urine to be tested, while at other times it will be

heavier. In order to most easily employ the overlaying method, it is essential that one of the liquids employed should be decidedly heavier than the other. The difficulty referred to is experienced in testing this sample of urine. The picric acid is of about the same specific gravity as the urine, and diffuses itself rather rapidly through it, but at the same time we notice a distinct white line indicating the presence of albumen. This difficulty is readily obviated by an expedient, which certainly does not diminish the delicacy of the test, while it is held by some that it increases it, and that is the addition of citric acid to the picric acid solution. This solution is prepared by adding to one ounce of a saturated solution of citric acid. This makes the test fluid heavier than albuminous urine is likely to be. Placing some of the solution in the test tube, I pour on it the urine, at opposite side of the tube to that on which I poured the picric acid. This is done because the small quantity of picric solution adhering to the side of the tube gives the urine an intense yellow, which is not desirable. We again have the white line, which is as distinct, if not more so, as that obtained by using pure picric acid.\*

There are certain disadvantages of the picric acid with or without the citric. One of these is that the color of the urine sometimes so closely approaches that of the picric acid that there is some difficulty in determining the line where the two join. This is, however, not a very serious objection. A more serious one is that quinine and the vegetable alkaloids generally are similarly precipitated, and as the former, at least, is often administered in such quantity as to appear in the urine, the white line thus produced may be mistaken for albumen. Peptones are sometimes found in the urine, and these are also precipitated by picric acid. Alkaloids and peptones thus precipitated are promptly dissolved

by the application of heat. Finally, the acid urates are precipitated by picric acid as they are by nitric acid, but these, again, are redissolved by a moderate degree of heat.

The next test to which I shall refer is the potassio-iodide of mercury, which, if properly prepared, is about as delicate as the picric acid test. This test which, was discovered by Mr. Charles Tanret, a French chemist, consists of bichloride of mercury, 1.35 grammes; iodide of potassium, 3.32 grammes; acetic acid, 20 cubic centimeters, and distilled water enough to make 100 c.c. The double iodide of mercury and potassium solution is perfectly colorless and transparent, and is used in the same manner as the picric acid. It is subject to the same objection as precipitating peptones, alkaloids and urates, also mucin, which is not precipitated by pure picric acid. It has the advantage of being colorless, and heavier than most urines. The sodium tungstate test consist of a saturated solution of sodium tungstate and citric acid. This solution does not precipitate the alkaloids, although it does throw down peptones and mucin.

There is no doubt but that, in the most delicate of these solutions, we have tests which will show quantities of albumen so small that they cannot be recognized in any other way. Picric acid and the mercuric iodide are the most delicate. But the sources of error which have been named make it necessary that they should be used with the utmost precaution. None of the objections named apply to the heat and acid test, which when used in the manner indicated, is extremely delicate—quite sufficiently so for practical purposes. For the present we may regard the others as practically most useful for proving and confirming the results by heat and nitric acid.

Following the example of the profession in this country, a conference of the representatives of all the medical institutions in Edinburgh, Scotland, was recently held to consider the advisability of having Post-Graduate courses of instruction for practitioners of medicine. To give the matter a practical test it is proposed to make arrangements for a tentative course to be held in September and October.

\*The disadvantage of the combined citric and picric acid solution exists in the fact that mucin is precipitated by the nitric acid; but the same is true of acetic and nitric acids, and as the result of a large experience, I am forced to conclude that no mistake can result from the delicate haze of diminished transparency thus produced.



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BALTIMORE, JULY 31, 1886.

**Editorial.**

THE MORTALITY OF THE CÆSARIAN SECTION.—On all questions relating to the Cæsarion section, Dr. R. P. Harris, of Philadelphia, has shown himself to be a most faithful and indefatigable student, and to his valuable statistical tables, which have been carefully compiled from time to time, the profession is indebted for most valuable facts relating to this procedure as they have been presented in this country and in Europe.

Dr. Harris' latest contribution to this subject (*Med. News*, July 17, 1886) is a most earnest defence of the Cæsarion section as recently modified by Dr. Sanger, of Leipzig, as contrasted with the procedure instituted by Porro, of Italy. Dr. Harris attempts to show by statistics that when the Cæsarion operation is performed under favorable conditions, and where the uterine wound is sutured so as to render it impervious to fluid and to secure an early union of its serous coat, the mortality is less than by the Porro operation and even less fatal than craniotomy in badly contracted pelvis.

"Thus far," he says, "there is no general or hospital record in any country to compare with the one herein given. Under the first 28 Porro operations, 18 women were lost, although all but 5 of the children were alive at delivery; and under the first 28 of the second hundred, 16 women and all of the children but 6 were saved; against which we place the

saving of 19 women and 24 children out of the first 28 Sanger cases at home and abroad. The best Porro record in any European maternity is that of Milan, where cases 1, 2, and 9 were fatal in a list of 14, under five operators. Under three operators in Leipzig and two in Dresden, the Sanger method shows a record of 6 women and 6 children saved in one maternity by 6 operators, and 9 women out of 10 in the other, with all of the children. The whole record of Germany foots up 21 operations with the loss of 3 women and 1 child." These facts read with marvelous interest and at once suggest the inquiry, whether the dangers of the Cæsarion section have not been over-estimated. We are again indebted to Dr. Harris for the true solution of this inquiry. Turning to the American tables we are informed by Dr. Harris the old story, "try every possible obstetrical expedient first, and then 'the forlorn hope' of the knife," is at the basis of the wretched results attending the Cæsarion section in our own country. "We have had, so far as known, 142 operations in the United States. Of the first 70 down to 1866, 37 resulted in the recovery of the women; and of the balance, 72, only 17 had a favorable result. Of the first 70 children, 35 were lost, and of the 72, 42 were found dead. Of the 70 there were 23 *timely* operations, saving 20 women and 20 children; and of the 72, only 10, undertaken early, saving but 3 women, although 9 children were extracted alive. By the increased mortality of the last twenty years, we have reduced the percentage results of twenty operations from 75, or 21 saved out of 28, to 69 $\frac{3}{4}$ , or 23 out of 33; and the general average of recoveries from 52 $\frac{1}{2}$  per cent. to a fraction over 38 per cent." In view of these facts it is suggested that it is quite time that we should follow the example of the German rather than the English operator. Dr. Harris asserts, correctly we believe, that in the Cæsarion operation we have more to fear from the condition of the patient prior to the use of the knife than from the surgery *per se*. The prognosis, he thinks, will depend upon the answers to the following questions: "1. Is the woman a dwarf?

2. Are her powers of endurance below standard by reason of having been rachitic childhood? 3. Has her strength been in wasted by long continued uterine action? 4. Has she been subjected to attempts at delivery by the forceps, turning or craniotomy? 5. Has the foetus died from uterine pressure, and if dead, has it become putrid? 6. Has it been partially delivered by turning or decapitation? 7. Is the woman syphilitic? 8. Are her kidneys unsound, showing albumen or pus in her urine? 9. Has she a uterine or pelvic tumor? 10. Has ergot been administered? If all these can be answered in the negative, there is but comparatively little risk in the operation in the majority of cases."

Having decided to operate under the conditions here mentioned, the question of selection of the procedure to be adopted next arises. The Sanger method, in view of recent statistics, seems to leave no doubt as to the propriety of a choice. This method requires for its success that the woman should be in a favorable condition, and that she should not by delay or futile expedients have lost her child. The Sanger operation owes its success to the careful method with which the uterine wound is secured against the possibility of leakage. In this essential particular it avoids all the elements of danger of the old operation, which depended largely upon the continuance of uterine contraction for the prevention of leakage into the abdominal cavity. The aim of the Sanger operation is to check excessive hemorrhage when the uterus is incised and to close the uterine wound by many sutures so that the parts will be held in close apposition without much individual strain upon the sutures.

Much time is required to perform the operation in all its details, but if this time be given to it, if all the details of antiseptic surgery be enforced, if the operation be performed before the patient's life is endangered by attempts at delivery in other directions, there is every probability of a successful issue.

THE LESSONS OF THE SERVO-BULGARIAN WAR IN REGARD TO THE ANTISEPTIC TREATMENT OF GUN-SHOT WOUNDS.—

During the past ten years the practice of surgery has been almost revolutionized. Not only are surgical procedures undertaken which a few years ago were unheard of, but the success of these, as well as of other more common operations, has been far beyond the wildest conceptions of even those who are now enjoying the fruits of this salutary change. The beginnings of these good things are due chiefly to the practical genius of Sir Joseph Lister, who introduced the "antiseptic system;" but his methods have been amplified and improved upon, so that at the present day the "antiseptic treatment" has a much wider signification than formerly. Up to the present time the efficacy of the antiseptic methods has been confined to civil practice almost exclusively. The great war of the rebellion, which has yielded so many practical results in regard to gun-shot injuries, was pre-antiseptic. At the time of the Franco-German war Lister was still comparatively unknown, and his method had not gained extensive adoption. Even the Turco-Russian war did not enjoy the advantages of the universal adoption of antiseptic principles. Since then only a few trifling conflicts have occurred, mostly in remote regions and more or less away from the refinements of modern surgery. There are, however, several subjects of the greatest importance which are waiting for occurrence of a great war, or a series of wars, for their final settlement. Amongst these is the question of laparotomy for penetrating gun-shot wound of the abdomen; the comparative results of amputation and conservatism in gun shot wound of the joints, and in severe compound fractures, the best antiseptic method for use on the battlefields, &c. The recent disturbances in Egypt and the Soudan afforded opportunities to a limited degree to test the virtues of antiseptic methods as applied to military surgery, and the results have been eminently satisfactory; but more favorable opportunities have been afforded by the war between Servia and Bulgaria, as the contending armies were not so far removed from observation, and volunteer surgeons and staffs were sent out from



Germany and Austria by various societies, fully equipped with all the necessary appliances for the treatment of gun-shot and other wounds. Amongst the surgeons who volunteered their services were Prof. Moseitig-Moorhof, Dr. Karl Maydl and Dr. Alex. Fraenkel, of Vienna, Dr. Hans Schmid, of the Augusta Hospital in Berlin, and our townsman Dr. Claphan Pennington, most of whom have written more or less elaborate reports of their work in the hospitals of Belgrade, the capitol of Servia.

Moseitig-Moorhof, in *Wein. Med. Woch. enschrift*, 1886, No. 16, records his experiences in the treatment of those wounded in this war. Moseitig is known as the introducer of iodoform into surgical practice, and as its most ardent advocate. He now declares that iodoform answers the purpose of an antiseptic for military practice better than any other agent, because it can be readily dusted upon wounds soon after injury, and in this way acts as a prophylactic antiseptic. He uses either iodoform in powder dusted on the wound, or iodoform gauze, then a piece of rubber paper to prevent too rapid drying of the secretions, and then an absorbent dressing. He treated 824 wounded, 252 gun-shot fractures and 572 flesh wounds. Of these 19, that is 2 $\frac{1}{2}$  percent., died, 4 of tetanus, 3 of fat embolism, 1 of thrombosis of the iliac vein, 1 of brain injury—2 were moribund when brought and the other 8 are not classified. Of 14 patients with fractures of the thigh 2 died, and 7 were amputated with no death. Of 13 penetrating wounds of the knee, 6 were amputated and 1 died. Of 20 compound fractures of the arm and forearm, 1 died, and 4 were amputated, of which 1 died. No case of iodoform intoxication was seen. The following summary represents Professor Moseitig's views in regard to the treatment of gun-shot wounds in time of war.

1st. In the first instance are only those antiseptic powders possible, which do not destroy tissue, and can be used in very small quantities, iodoform is for this purpose the best antiseptic.

2d. For the second and third classes a pure iodoform dressing is quite sufficient,

and the results are as good as when sublimate or carbolic acid has been used.

3d. Iodoform is much less dangerous for organism. The result mentioned above seem to have been eclipsed by Dr. Alexander Fraenkel, chief of the German Ritter Ordens Hospital who treated 403 wounded patients with but five deaths, or 1 $\frac{1}{2}$  per cent. One from internal hæmorrhage from a penetrating wound of the chest, one of septicæmia, two of tetanus and one of erysipelas. Of 114 fracturers, including two of the shoulder joint, three of the elbow, two of the wrist, all healed after appropriate operations, removal of fragments, partial resection, etc. In no case was amputation necessary. This is a remarkable fact since Moseitig found it necessary to amputate seventeen times, though it is probable that his cases were of a greater degree of severity. Fraenkel sums up his experience in the following sentences: 1. Compound gunshot fractures scarcely demand at the present time primary amputation. 2. Primary amputation is indicated at most only in compound fractures from heavy weapons, which are accompanied by irreparable destruction of soft parts. 3. For the secondary antiseptic treatment use the most rigid antiseptic therapy and avoid intermediate and secondary amputation. 4. Gunshot wounds of the joints even after suppuration has been established, should be treated antiseptically and conservatively. In consequence of the markedly better functional result typical resection should be avoided as much as possible and partial resection substituted for it. Fraenkel used sublimate, carbolic acid and iodoform as antiseptics, with the above remarkably favorable results. It is of interest in this connection that the King of Servia has become so impressed with the value of antiseptics that he has officially ordered, "that hence forward the antiseptic plan of treatment be solely used in all the hospitals of our kingdom, and that corrosive sublimate and iodoform be used until our further disposition." Fraenkel pleads that nothing should be done on the field except to put on an antiseptic dressing, and that the necessary operations and dress-

ing should be performed in the field hospital, where all the clinical advantages should be attainable.

Dr. Hans Schmid (*Centralblatt fuer Chirurgie* 1886, No 12) presents about the same experiences in regard to the antiseptic treatment of gunshot wounds. Arriving six days later than Mosetig and Maydl, he was assigned to a hospital of 93 beds, which were immediately filled with wounded who had received no treatment, notwithstanding ten days had elapsed since their injury. Subsequently the arrival of fresh instalments of wounded led to his undertaking a second hospital, so that in all about 200 patients came under his treatment, with 3 deaths, 2 from tetanus and 1 from exhaustion after a hip-joint exarticulation. 25 of these cases were extraordinarily severe. The antiseptics used were sublimate solution, carbolic acid for instruments, and iodoform. In all of these cases secondary antisepsis had to be employed, as five to ten days had elapsed since the injury. It is noteworthy that many cases which had had no adequate treatment were found healed when they came under observation.

Besides the surgeons mentioned above, others from Russia, Hungary and other countries rendered efficient services, so that altogether 3100 wounded were treated in the hospitals of Belgrade with only 51 deaths, and of these 22 died of tetanus and, indeed, according to the printed reports, all the cases of tetanus terminated fatally. None of these surgeons had the opportunity of being near the contending armies, as only Servian surgeons accompanied their troops, hence the observations were not made upon or near the field of battle, and do not relate to primary antisepsis. It is all the more to be wondered at that of 3100 persons more or less severely wounded, only 51, or 1.6 per cent., should have terminated fatally, hence it may be stated that the war between these diminutive countries has at least solved, to a large degree, the problem of the value of antiseptic treatment in military surgery.

### Miscellany.

**THIRST AND DRINKING IN HOT WEATHER.**—So far as the mere sensation of thirst is concerned, there can be no question that it is a mistake to drink too much or too frequently in hot weather; the fluid taken in is very rapidly thrown out again through the skin in the form of perspiration, and the outflow being prompted by this determination toward the surface, a new and increasing demand for fluid follows rapidly on the successive acts of drinking and perspiring, with the result that "thirst" is made worse by giving way to it. Meanwhile, it must not be forgotten that that thirst is Nature's call for fluid to replace that lost by cutaneous exudation in warm weather; and if the demand be not met, what may be regarded as the residual fluid of the tissues must be absorbed or the blood will become unduly concentrated. Now, this absorption of the residual fluid of the tissues has the obvious drawback of taking into the blood in a concentrated instead of a dilute form the products of disassimilation, together with the absorption of some excrementitious matters which would probably not be taken up at all if the blood were not abnormally dense. It is necessary to recognize that harm may be done by a process of self-poisoning with excrementitious matter, retained, or taken up, in default of an adequate supply of fluid in the form of drink to dilute and wash it away. There is, moreover, another disadvantage of the non-drinking method of suppressing thirst. It is especially needful for the preservation of health that the metabolism on which the normal nutrition depends should be rapid and free in hot weather. If the organic temperature is, or more accurately if the several complimentary temperatures of organism are, to be maintained at the health point, tissue-change must be favored, and such modifications of body-heat as may be effected by flushing and evaporation must be facilitated. In short, if we refuse to drink when we are thirsty simply because we shall thirst again, we are imposing a restraint on the activities by which Nature is endeavor-



ing to preserve the health. We are doing precisely what the irrational homœopaths do, or did, when refusing fluid to cholera patients or limiting the drink of those who suffer from fever. Of course, like produces like in the matter of thirst from any cause, but the like produced is natural; and it is, or rather was, strange to note that in one of the earliest notorious cases of malpractice by persons calling themselves homœopaths in England the dogma "*Similia similibus curantur*" should be flung to the winds, and drink refused to a patient dying of liquid diarrhœa, because, forsooth, the taking of fluids increased the diarrhœa and made him more thirsty! We venture to hope that those who are zealously urging the policy of refusing to quench their thirst in hot weather because "drink makes people more thirsty" will reconsider their policy from the physiological standpoint, and that they will recognize that to thirst and drink, and perspire and drink again, are the natural steps in a process in which Nature strives so to maintain the integrity of those organic changes which the external heat has a tendency to impede. The natural and true policy is to supply an adequate quantity of fluid without excess. Therefore do not abstain from drink, but drink slowly, so as to allow time for the voice of Nature to cry "Enough." There is no drink so good as pure water. For the sake of flavor, and because the vegetable acids are useful, a dash of lemon-juice may be added with advantage. The skin should be kept fairly cool, so that a sufficient quantity of the fluid taken may pass off by the kidney.—*Lancet*, July 10, 1886.

**MALTINE WITH CASCARA SAGRADA.**—The value of cascara-sagrada in all cases of obstinate and habitual constipation is conceded by nearly the entire medical profession. To improve the value of the cascara, The Maltine Manufacturing Company, of New York, has recently brought out a preparation in which maltine is combined with this well-known laxative. The effect of the combination is to render the cascara a safe and agreeable laxative, while the maltine invigorates and strengthens the whole system.

This purgative causes no pain, nor does it leave the bowel in a weakened or enfeebled state, having on the contrary a tonic action.

**SOME CERTAINTIES IN THE THERAPEUTICS OF EPILEPSY.**—Dr. C. L. Dana has written a paper with the above title, which is published in a recent number of the *N. Y. Medical Journal*. His conclusions are summarized in the following statements:—

I. Diet, exercise and proper hygienic treatment rank above all other single therapeutic measures.

II. The bromides take the second rank in the treatment of epilepsy.

All bromides act alike in this disease. If one does not cure another will not. Occasionally changing and mixing reduces the attacks for a time, and benefits the stomach.

III. The best bromides are those of potassium, sodium, ammonium, and hydrogen (hydrobromic acid); possibly we may add nickel.

IV. Bromides may be given in daily doses of 3j, increased gradually until the attacks are suppressed, or the dose reaches 3iv to 3j daily. Few patients can tolerate more than this latter dose. Thorough bromidization should always be tried, if necessary to stop fits, and it may be occasionally repeated. But bromidization is sometimes injurious, even making the disease worse, and it must always be employed with caution.

V. When the fits are suppressed, the bromides should be carefully reduced, but never entirely stopped for at least two years after the last fit.

VI. In most cases, and especially in nocturnal epilepsy, an extra large dose of bromide should be given at night.

VII. It is very important that bromides should be chemically pure, that their use should be continued a very long time, and that their depressing effects should be offset by tonics and all possible roborant measures.

VIII. The best non-specific adjuvants (drugs) to the bromides are potassium iodide (in syphilitic epilepsy), potassium bicarbonate (in lithæmic and rheumatic states), carbonate of ammonium, the hy-

pophosphites, arsenic, iron and quinine.

IX. The other chief adjuvants to the bromides are diet, exercise, a regular life, hydrotherapy, counter-irritation on the neck, and, in the line of drugs, zinc, belladonna, strychnine, valerian and the nitrites. Combinations of bromides with the other drugs mentioned will lessen attacks when bromides alone will not.

X. The best substitutes for the bromides, when these do no good or do harm, are belladonna, zinc, strychnine, glonoin, borax and alteratives.

For nocturnal epilepsy, increase the dose of bromide at night, and add chloral or digitalis. Give also, if needed, strychnine. Raising the head of the bed or making the patient sleep in a chair at night are measures to be tried.

For the status epilepticus give large enemata of chloral, and use emetics and purges. Venesection is often efficacious, morphine is dangerous, chloroform is only palliative, and nitrite of amyl is of little value.

**RADICAL CURE OF VARICOCELE BY EXCISION.**—*Il Bullettino* of the Royal Academy of Medicine of Genoa (No. I., 1886) reports a case in which Professor Ceci successfully treated a large left varicocele by excising the dilated spermatic venous plexus. The patient, aged twenty-two, suffered great inconvenience in consequence of the enlargement. Under chloroform, an incision two and a half inches long was made on the left outer side of the scrotum down to the vein, the distension of which was maintained by an assistant exercising pressure at the external abdominal ring. With a director, the vas deferens and the spermatic artery were carefully isolated from the vein, which was secured with two catgut ligatures at the abdominal ring and near the testicle. The varicose venous plexus was then excised. The skin wound was closed with a catgut suture, a drainage-tube having been placed in the lower angle. On the eighth day, when the dressing was changed, there was some œdema of the scrotum; this part as well as the inner surface of the thigh was the seat of carbolic eczema, and carbolic necrosis had

attacked the edges and the bottom of the wound. These symptoms disappeared under borax and iodoform, and the patient made a perfect recovery. Professor Ceci considers that the technical progress in operations for varicocele due to the influence of aseptic and antiseptic precautions, justifies preference for excision of the vein over difficult and complicated methods. — *Lancet*, June 26, 1886.

**ON THE TREATMENT OF NEVUS.**—At a recent meeting of the Clinical Society of London, Mr. R. W. Parker stated that he divided nevi into three chief classes, the cutaneous, the subcutaneous, and the mixed variety, the last mentioned being by far the most numerous. For cutaneous nevi one of the simplest and most efficacious methods of treatment was the application of fuming nitric acid; for the subcutaneous variety, he advocated electrolysis or excision; for the mixed variety, excision was regarded as the surest and most speedy as well as the most radical method.

Mr. Golding Bird has found good results from the ligature. He took exceptions to the sweeping statement that excision should be applied to all cases. Ligature was much preferable in cases which occurred in out-patient practice. A less scar ensued after ligature than after excision, and this latter method was inapplicable to scalp nevi. In nevi below the lower eyelid, and at the end of the nose, the galvanic cautery alone could be employed, and neither ligature nor excision could be, in this situation, adopted. Properly employed the cautery left a minimum of scar and the least amount of contraction, cicatrization being slow, and cauterization frequent at first; in all such treatment the cautery should invariably be applied circumferentially. Mr. Golding Bird had lately employed the practice very often.

Dr. Ward Cousins thought the knife was the best treatment in some cases, but in others the worst. Some nevi got well under any treatment whatever. Nevi affecting the lids and nose, etc., ought to be very slowly treated; he him



self treated them by frequent and long-continued scarification by a knife. He approved of the large use of the actual cautery, and never now employed injection, and never used the ligature under any circumstances whatever.

Mr. Parker, for nevi about the nose and eyelid, employed electrolytic needles. He advocated excision as being a radical cure, and because the after treatment was so simple, especially when the edges could be brought well together.—*Amer. Practitioner and News*.

**ARSENIC IN SKIN DISEASES.**—The editor of the *Journal of Cutaneous and Venereal Diseases* is desirous of ascertaining to what extent arsenic is used by American physicians in the treatment of skin diseases, and also the results of their experience as to its therapeutical value.

Information upon the following points is requested of every physician who reads this:

Are you in the habit of employing arsenic, generally, in the treatment of skin diseases?

In what disease of the skin have you found arsenic of superior value to other remedies?

What ill effects, if any, have you observed from its use?

What preparation of the drug do you prefer, and in what doses do you employ it?

Address, Editor of *Journal of Cutaneous and Venereal Disease*,  
66 West 40th Street, New York.

**THE USE OF LEMONS IN THE TREATMENT OF INTERMITTENT FEVER.**—According to the Paris correspondent of the *American Practitioner and News* (June 12, 1886), Dr. Maslennikoff has treated twenty cases of intermittent fever with a decoction of lemons. Seven of the patients were affected by the fever for the first time, three for the second, and the rest having passed previously through several malarial attacks. In thirteen of twenty cases a quotidian, and in seven a tertian variety was present. In sixteen cases the spleen was found to be enlarged and painful; in fourteen, both during the paroxysms and the intervals.

The decoction was prepared after Maglieri's method,—that is, every evening a whole fresh lemon was cut into very thin slices, put into eighteen ounces of distilled water in an earthen pot, and boiled (for two hours) until six ounces of the decoction remained. On the next morning the liquid was forcibly strained through a piece of guaze, and then given the patient to take immediately in several gulps. The decoction was used in that way for ten or fourteen successive days. In none of the patients did any gastric disturbances occur.

The results obtained by Dr. Maslennikoff were not so successful as those by Dr. Putakhin and others. In only six cases, four of which were of quotidian fever and two of tertian, a cessation of the paroxysms ensued. For two of the remaining patients the paroxysms became less severe, and in three the type of fever underwent a change. In none did any alterations in size of the spleen take place. All cases where the decoction of lemons had failed were subsequently mostly very rapidly cured by quinine. The general conclusion reached by the authors is that, as far as severe Caucasian fevers are concerned, decoction of lemons has, except its agreeable taste and harmlessness, no advantages whatever over other substitutes for quinine.—*Ther. Gaz.*

**HIMROD'S ASTHMA CURE**—This proprietary medicine, which has attained a certain reputation in the treatment of asthma, is said to consist of a mixture of coarsely-ground stramonium-leaves and lavender-flowers with a little benzoin, the whole sprinkled with sufficient of a saturated solution of nitrate and chlorate of potassium to make the powder barn well. Another formula consists of equal weights of powdered lobelia, stramonium, black tea and nitrate of potassium, well mixed and sifted. Dr. Morell Mackenzie, quoting the last formula, recommends the addition of a little aniseed or fennel. A French formula advises stramonium and sage. The foregoing may or may be identical with the proprietary article, but in case they share with it the power of alleviating and cut-

ting short the troublesome attacks to which sufferers from asthma are liable. It is an unsatisfactory feature of even the best remedies that they ultimately fail to produce their relief which first attend their use.—*Med Press and Circular*, May, 26, 1886.

**DIAGNOSIS OF GONORRHOEA IN THE FEMALE.**—If there is any clinical truth in the statement put forward at a meeting of the Paris Obstetrical and Gynaecological Society by Dr. Martineau, a most important means of forming a true diagnosis is in the hands of medical men and one which will save them much worry and anxiety. Many cases arise in which it is of the utmost importance a correct decision should be arrived at. It is claimed that in the case of gonorrhoeal discharge the latter is always acid, while in the simple form of vaginal discharge it is alkaline. The reaction upon litmus-paper in this case settles the question. This would also form a very valuable means of deciding in cases of rape in which the persons committing the crime were supposed to have been suffering from gonorrhoea at the time, and to have imparted the specific disease to the victim. Further evidence may be looked for to establish what, if true, will be a great step in advance in our clinical knowledge of the subject.—*Medical Press*, June 2, 1886.

**PREVENTIVE INOCULATION OF YELLOW FEVER.**—Dr. Meyrignac employs the sediment of the urine of yellow fever patients, which contains the zoöspores of the peronospora lutea, and injects it, dissolved in distilled water, with a Pravaz's syringe. Three hundred Mexicans were inoculated before the epidemic of 1884, and not one has died. Inoculation is generally followed by an abortive attack of yellow fever, the symptoms being benign, slight, incomplete, and of short duration. This modified yellow fever seems to confer complete immunity from a second attack.—*Lond. Med. Record*.

**A NOVEL METHOD OF TREATING HYS-TERIA.**—Ruault (*France Médicale*) affirms that he has frequently controlled

an hysterical fit by making firm pressure with the thumbs on the supraorbital nerves at the supraorbital foramina. The patients are described as first contracting the facial muscles as if in pain; they then cry out and take several inspirations, followed by a long expiration. They now relax their muscles, and the convulsion is at an end. Pressure should not be maintained after this, lest another attack be excited.—*N. Y. Med. Journ.*

**A NEW METHOD FOR ANÆSTHETIZING THE UNINJURED SKIN WITH COCAINE.**—Dr. Wagner, at the meeting of the Society of Physicians at Vienna, held February 5, 1886, described a method by which the uninjured epidermis might be rendered anæsthetic through the application of cocaine. For this purpose he made use of the property of a galvanic current discovered by Dr. Haertner, in consequence of which fluids move from the positive to the negative pole. If the positive electrode is dipped in a cocaine solution, and placed upon the skin, and the negative pole placed a short distance from it, and a current allowed to pass, the skin lying between these two points of application of the electrode becomes anæsthetic. Wagner made a number of experiments to determine the value of this method to surgical practice in the clinic of Prof. Billroth, and found that by the means of this such anæsthesia as would prevent the appreciation of incisions of the skin was readily attainable.—*Wein. Med. Blatt. — Therapeutic Gazette*.

**A NEW METHOD FOR THE REMOVAL OF INTRAMURAL UTERINE TUMORS.**—Dr. O. Stroinski, of Chicago, writes to the *N. Y. Med. Record* (June 19, 1886) as follows: "After severe losses in removing intramural uterine tumors through the abdominal or vaginal walls, I decided either to abandon entirely any attempts of extirpation of these tumors, or to find a method that would give a reasonable show of favorable results. Lately I have found that continued intra-uterine injections with diluted subsulphate or sesquichloride of iron produce a discharge of



mucous membrane, as well as of muscular stratum, and that, combined with the effect of contractions always evoked by these injections, causes the intramural tumors to be forced into the uterine cavity, where they may easily be seized and extracted. I will give the minute details of these proceedings at another time, and will now merely formulate the conclusions which I have arrived at after a careful study and a good deal of experience: 1. Extirpation of intramural uterine tumors through the abdominal or vaginal walls is as unnecessary as it is dangerous; while, 2. There are certain procedures which always transform the intramural into an intra-uterine tumor, which can be easily extirpated; 3. These procedures only should be made use of in the removal of intramural tumors, being entirely harmless, and never endangering the life of the patient nor maiming the sexual organs; 4. Even the largest myoma might be easily removed by this operation; 5. Only tumors situated on the surface of the uterus are excluded from this procedure. I have operated on cases in which large doses of ergot had been taken for a long time without the slightest effect, and in one case in which the tumor had existed before marriage, and a child had been born without the tumor losing its size or changing its position. I will furthermore say, that I have operated in private as well as hospital practice, so that there cannot be any doubt of the reality of the facts."

**THE TREATMENT OF CONSTIPATION BY MASSAGE.**—In the introductory lecture to the course of Pharmacology and Therapeutics delivered at the Westminster Hospital Medical School, Dr. Murrell referred at some length to the good results recently obtained in the treatment of habitual constipation by means of massage. The method he employs is a modification of that originally introduced by Mezger and Von Mosengel. *Pétrissage* of the abdomen is of essential value, the manipulations being performed in the direction of the ascending transverse and descending colon. It is usually associated with various forms of

*tapotement*, for the production of which the open hand, the partly closed hand, or its radial or ulnar border, may be employed. Vibratory movements are resorted to in obstinate cases, and it was stated that the action was usually remarkably prompt and certain. The best results were obtained in cases of constipation associated with obesity, especially when the patient was unable to take much exercise. It probably acts in three ways,—(1) by increasing the intestinal and other secretions; (2) by stimulating the peristaltic action of the intestines; and (3) mechanically, by pressing the accumulated feces towards the rectum. The treatment is well-known on the continent, and will, doubtless, in time be generally recognized in this country.—*Medical Press*, May 19, 1886.

**PAINLESS REDUCTION OF SHOULDER DISLOCATIONS.**—Dr. Maclead, of Shanghai, gives the following directions for the reduction of sub-glenoid dislocations without an anæsthetic: "Let the patient lie down on his back on the floor or ground, with the dislocated arm outstretched at right angles to the trunk, and also on the floor. Having told the patient to lie quite still and make no effort, let the surgeon, placing the approximate heel in the axilla, make traction gently and steadily at right angles to the line of the trunk; and, as there may be no jerk or evident intimation of the return of the head of the bone to its place, let him ascertain its position, if necessary adducting the limb to make sure; if reduction has not taken place, let him renew and increase the force of traction, and repeat the examination until he has succeeded or failed, in which latter case nothing has been done to interfere with other methods. It is possible that, in many cases, the heel in the axilla may be unnecessary, but it will serve to steady the scapula, and affords a better counter-extending force than the weight of the patient's body, and thus leaves him free to lie still and make no effort as if to aid."—*Brit. Med. Jour.*

**DIETETIC FALLACIES.**—1. That there is any nutriment in beef-tea made from

extracts. There is none whatever. 2. That gelatine is nutritious. It will not keep a cat alive. Beef-tea and gelatine, however, possess a certain reparative power, we know not what. 3. That an egg is equal to a pound of meat, and that every sick person can eat them. Many, especially those of nervous or bilious temperament, cannot eat them; and to such, eggs are injurious. 4. That because milk is an important article of food, it must be forced upon a patient. Food that a person cannot endure will not cure. 5. That arrow-root is nutritious. It is simply starch and water, useful as a restorative, quickly prepared. 6. That cheese is injurious in all cases. It is, as a rule, contraindicated, being usually indigestible; but it is concentrated nutriment, and a waste-repairer, and often craved. 7. That the cravings of a patient are whims and should be denied. The stomach often needs, craves for, and digests articles not laid down in any dietary. Such are, for example, fruit, pickles, jams, cake, ham, or bacon with fat, cheese, butter, and milk. 8. That an inflexible diet may be marked out, which shall apply to every case. Choice of a given list of articles allowable in a given case must be decided by the opinion of the stomach. The stomach is right, and theory wrong, and the judgment admits no appeal.—*Technics*.

### Medical Items.

The Hospital Sunday Fund recently collected in London for 1886 amounts to £31,000, or £5,000 more than in the corresponding day of last year.

Dr. William Froebetius, formerly a great ophthalmic surgeon in St. Petersburg, Russia, is dead. He was the first to perform iridectomy for glaucoma in St. Petersburg.

A resolution has been introduced into Congress by Mr. Swinburne, of New York, authorizing the Surgeon-General to collect statistics on hydrophobia in this country, and directing a report on the subject to Congress at its next session.

In 1880 the price of quine was \$3 per ounce, whilst at the present time it is selling at 52 cents. This great reduction is due to an increased supply growing out of the cultivation

of the cinchona tree in Ceylon and Java, and to the removal of all tariff duties by the Government. Formerly the consumers of the drug in this country were taxed enormously to sustain monopolists engaged in the manufacture of the various preparations of the bark. Free quinine is one of the most benevolent features of a free tariff.

The Secretary of the Board of Health, of Baltimore, has made a compilation of the number of deaths annually and in the aggregate from typhoid-fever for eleven years—1875-85—1904; 173 1-11 per annum: *One in every 46.5 of the deaths from all causes*. The money value of these lives and the costs involved in their sickness and death, estimated at the usual value of lives in the prime of life—those commonly carried off by typhoid-fever—the sum squandered in this criminal mortality would have been sufficient to sewer the city.—*The Sanitarian*.

THE LATE MR. W. WHITE COOPER.—The London *Gazette* announces that "the Queen has been graciously pleased to ordain and declare that Mary Elizabeth Cooper, widow of William White Cooper, Esq., Fellow of the Royal College of Surgeons, Her Majesty's Surgeon-Oculist in Ordinary, deceased, shall henceforth have, hold, and enjoy the style, title, place, and precedence of a widow of a Knight Bachelor of these realms, in as full and ample a manner as she would have enjoyed the same had her husband survived and received the dignity of a Knight Bachelor; and to command that the said Royal Order and declaration be registered in Her Majesty's College of Arms."—*Lancet*, July 10, 1886,

The London *Lancet* in calling attention to the fact that the house in which John Hunter lived at Earl's-court has recently been demolished, makes the very earnest plea that the place, formerly occupied by the house, and now being laid out as a square, should be named after the great anatomist who here kept his caged lions, prepared the skeleton of O'Brien and layed the foundation for the magnificent collection at Lincoln's-inn-fields. The builders have obtained permission to name the square "Barkstone-gardens," which the *Lancet* says may not be inappropriate in itself, but that the occasion surely warrants that the greatest person and circumstance connected with old old Earl's-court house should be fixed upon to give the new nomenclature. "We have placed 'Cleopatra's Needle' on the Thames embankment to commemorate, as we suppose, the 'dalliance and the wit' of the swarthy Egyptian queen. Thousands of pounds were spent to bring and rear in our midst an obelisk of uncertain history. Why, then, should we from simple negligence fail to honor, if only by a name, one who has done thousand times more to make the world healthful and happy than she who 'rode on Fortune's neck' and governed men by change."



Original Articles.

A STUDY OF THE VARIOUS METHODS OF TREATING OTORRHOEA.\*

BY HIRAM WOODS, M.D.,

Assistant Surgeon in the Presbyterian Eye, Ear and Throat Charity Hospital.

The word "otorrhœa" means a "running ear." As Professor Roosa points out, it is wrong to use the word as the *name* of a disease. It is only a *symptom* of an inflammation in the deep structures of the ear, usually commencing in, and frequently limited to, the tympanic mucous membrane. The character of the discharge varies; at times it is a thin, sanious liquid (catarrhal otorrhœa) while again it is muco-purulent or purulent.

The means adopted for the relief of this common and dangerous trouble must, of course, vary with the conditions present. The presence of foreign bodies, masses of inspissated secretion, polypi, dead bone and other complications require special treatment. Apart from these, however, there is a large number of cases which daily come under our care, where the disease has its seat solely in the mucous membrane of the middle ear, and remedies need be directed only to this structure. It is the treatment of these uncomplicated cases that I wish to discuss in this paper.

I. *Constitutional Treatment.*—In the employment of this method the main reliance is placed upon the power of certain drugs to stop suppuration. Mercury and calcium sulphide are the remedies usually employed. Dr. Sexton, of New York, strongly recommends them; mercury, when the disease is catarrhal in its nature, calcium sulphide, when the discharge is purulent.

At the meeting of the American Otolological Society, at New London, in July, 1885, Dr. Sexton recommended these drugs in the treatment of "inflammation of the attic of the tympanum"—one of the most obstinate forms of otitis media. In the discussion which followed his

paper he remarked that he would "give up local applications rather than the internal remedies he had recommended." (*Philadelphia Medical News*, July, 25th, 1885. Paper in full in *American Journal of Medical Sciences* for October, 1885).

Dr. Theobald, of this city, is quoted in Professor Roosa's work on the Ear as having had success with mercury. Beyond the use of a purgative dose of calomel at the commencement of the attack, and of small doses of mercury for syphilitic cases, Professor Roosa condemns both it and calcium sulphide. Neither Burnett nor Politzer recommend this form of treatment.

With these various opinions on the subject, I tried calcium sulphide in several cases at the Presbyterian Eye and Ear Hospital several months ago. It was given in practical doses "ter in die," and local treatment was confined to wiping away the discharge as it appeared. I could not see that it did any good. In all the cases I finally resorted to local treatment. I have, however, used it with private cases with most gratifying results. One patient was a gentleman, 24 years of age, whom I first saw in the last week of March, 1885. His otorrhœa was the result of an acute otitis media ending in perforation of the membrana tympani, and was of three months duration. The lower and posterior quadrant of the drum membrane had been lost by ulceration, and the gap was filled with small polypi and granulation tissue. The discharge was copious and purulent. With the snare I removed as much as possible of the granulation tissue, and then instituted the alcoholic treatment. This was continued till May 31st. There was then a slight decrease in the discharge, and the granulations had disappeared. The "*dry treatment*" was now employed during the first two weeks in June, and had no effect whatever. From then to the end of July, zinc, alum, ergot, alcohol and other remedies were employed, and seemed only to *increase* the discharge. On July 28th, I ordered sulphid. calcii. gr. i, every four hours. To my surprise the copious discharge ceased entirely in

\*Read before the Baltimore Academy of Medicine

forty-eight hours. It has not since returned. His condition one month latter was: perforation sealed by a thin layer of wax—which, following the advice given by Dr. Burnett in his "Treatise on the Ear," I let alone. Hearing for watch  $\frac{1\frac{3}{4}}{4\frac{3}{4}}$ . In March it was  $\frac{c}{4\frac{3}{4}}$ .

Another patient was a lady whom I saw in August 1885. She had otorrhœa of one week's standing; small linear rent in lower and anterior quadrant of drum; discharge purulent. Under 1 gr. doses calcii sulphid. the discharge ceased in twenty-four hours. During an acute choryza two weeks later there was a slight relapse. On account of the disagreeable gastric disturbances set up by the calcium at its previous administration, I now employed the powdered boracic acid locally with immediate benefit.

I believe there are certain conditions which specially call for this constitutional treatment, though as yet we do not know precisely what they are. At present, it seems to me that its utility is confined to cases in which there is the following state of things: a *purulent* discharge, a mucous membrane free from granulations or ulceration, and an absence of any sign of necrosed bone.

II. *Local Treatment.*—*Cleanliness* is the cardinal principle of *every* form of local treatment. According to the "wet" or "moist" method, the syringe, aided by Politzerization, is the usual means of cleansing the ear. Whatever water may remain in the ear after syringing is wiped out and the medicine is introduced in *fluid form*, allowed to remain in the ear a few minutes, and then the *unabsorbed* fluid allowed to run out. These medicines are generally astringents.

In 1879 Professor Bezold, of Munich, established the fact that the same antiseptics should be applied to the ear which now prevails in general surgery. (Article by Dr. C. A. Todd, *Philadelphia Medical News*, Dec. 1 1883). For this purpose he used a saturated solution of boracic acid. The antiseptic method, in one form or another, has now taken the first place in the treatment of otorrhœa. Its efficacy seems to

lie chiefly in the power of antiseptic agents to prevent the decomposition of the discharge in the tympanum. "The presence in this cavity of masses of decomposed pus leads to the spread of the inflammation, ulceration of the mucous membrane, and necrosis of the bony walls of the cavity. These conditions keep up the discharge, even if they do not—as frequently happens—threaten life by cerebral inflammation or septicæmia." (Poltizer).

The use of *powders* in the ear dates back many years. It was, however, only in 1880 that a "dry antiseptic method" was scientifically established. Dr. C. A. Todd, of St. Louis, read a paper during that year before the Missouri State Medical Association on the advantages of a strictly dry treatment of otorrhœa. He was the first in this country to publish this method (*Philadelphia Medical News*, May 26, 1883). According to this method the ear is to be cleansed by means of absorbent cotton on an applicator. The external meatus and tympanic cavity are *wiped* dry. Politzerization is an important adjunct in this as in all methods. After the ear has been cleaned, a dry, antiseptic, and (preferably) soluble powder is gently blown into the ear. Unless sooner saturated by the discharge, it is to remain for several days—ten or twelve. If sooner saturated, it is to be removed, the ear again wiped clean, and the powder re-applied. This method of treatment has proved an invaluable addition to aural therapeutics. Dr. Burnett, of Philadelphia, gives comparative tables of fifteen cases treated by the wet and dry methods. The average number of days under treatment for each patient was 212 by the wet and 17 by the dry method. A study of these tables also shows a larger percentage of *cures* and a smaller percentage of *relapses*, when the dry method is pursued. The dry treatment allows the use of the syringe only when the discharge is so excessive that it cannot be removed by the cotton, or when the tympanum is filled with masses of inspissated secretion. Dr. Burnett thinks it should be used in about one case in a hundred when the treatment is



conducted at the patient's home, and his physician cannot see him daily. Home cleaning should usually be limited to wiping out the discharge with a pencil of absorbent cotton. Dr. Burnett also claims that by dropping fluid medicines into the ear we furnish *moisture* to a *heated cavity* thus tending to *produce* granulations, and perpetuate the discharge. He also thinks that if zinc solutions are used, there is danger of producing aspergillus in the ear (*American Journal of Medical Sciences*, January, 1883, and Burnett's Treatise on the Ear).

Prof. Roosa, of New York, advocates the old moist treatment. He holds that "it is indisputably sound doctrine that cleansing must precede the use of any agents, and that thorough cleansing is impossible in many cases without the use of the syringe. He objects to powders because: (1) "they are not always absorbed, and they sometimes leave a troublesome irritating mass behind." (2) "they occasionally impair the hearing by mechanically obstructing the passage of sound waves." In reply to Dr. Burnett's remark that the moist treatment may, in many instances, keep up the discharge, he says: "If by this language it is meant that careful cleansing of a suppurating ear with warm water and the subsequent instillations of solutions is in many instances a bad surgical method, I can only answer that this statement, according to my experience, is not borne out by facts." So far from warm water producing granulations, he has, he says, frequently seen them disappear entirely with no other treatment than syringing with warm water. He does not believe that zinc drops will cause aspergillus in the auditory canal. (Treatise on the Ear.)

Prof. Politzer lays great stress upon the usefulness of his own method of inflating the eustachian tube in the treatment of otorrhœa. As regards local treatment he gives the first place to antiseptics. Powdered boracic acid is the remedy most generally serviceable. It is specially adapted to *acute otitis media*. When used in chronic cases, it should be persevered with, "for it is less likely to

be followed by reaction than other remedies," and frequently does not begin to lessen the discharge until it has been used a long time. In some cases, especially acute ones, it acts with great rapidity. It does not do much good, (1) "in cases of great proliferation of the mucous membrane," (2) "when there are granulations in the outer and middle ears," (3) "in cases of excessive desquamation in the middle ear, and (4) "when there is persistent offensive exudation." Other antiseptics, as carbolic, salicylic acids and iodoform are also used with benefit.

For *granular* suppuration Politzer recommends alcohol. Its action is specially slow, but it is very seldom followed by any reaction, dries up the granulations effectively, penetrates deeply into the recesses of the tympanic cavity, and is specially adapted for home treatment.

The caustic treatment by nitrate of silver—first brought forward by Schwartze—he considers, with its proposer, to be specially adapted to "cases of uncomplicated tumefaction of the mucous membrane, without granulations." It should not be continued unless it does good after eight or ten applications, and should never be entrusted to the patient. It is not appropriate until the antiseptic method has failed, and then should never be used in a *painful* ear or wherever we suspect dead bone. (It may be remarked, in passing, that many of our American otologists speak highly of a saturated solution of nitrate of silver as a remedy in *granular* suppuration. Politzer has, also, used it with success in such cases.) The use of astringents Prof. Politzer recommends only after the other methods have failed. The mineral salts are apt to form hard masses with the muco-purulent secretion, and are liable to cause relapses and *permanently* impair the hearing.

Concerning the moist and dry methods of cleansing and treating the ear, he admits that "occasionally a discharge is increased by the syringe, and rapidly decreases when the injections are discontinued." Still, he prefers the syringe to dry cleansing in the majority of cases

"because the secretion can never be so thoroughly removed by the latter as by the stream of water." He does not think the use of the syringe will cause granulations, and advocates its use because "in those cases of otorrhoea in which the meatus is daily washed out, the exudation is generally very moderate and has no bad smell, the mucous membrane of the tympanum remains smooth, and there seldom occur symptoms of reaction." Whereas, if the syringe is neglected, "we frequently find at our first examination inspissated masses of secretion full of micrococci and vibrios lying in the interior; and on their removal polypoid growths and granulations on the membrana tympani and the mucous membrane of the tympanum." Also, these secretions remaining in the tympanum "prevent the escape of pus from the cellular air-spaces of the petrous bone and the mastoid process," and necrosis may follow. He concludes that while no definite indications can be given, the dry treatment gives more favorable results in the acute form of the disease, should be employed when violent giddiness is set up even by weak injections, and in "those suppurations of the middle ear with watery or profuse blennorrhagic secretion in which the suppuration has not been diminished but rather increased by the continued use of injections." He considers it contra-indicated, "when the exudation has a bad smell, is in a crumbly condition, or when the lining membrane of the meatus or the mucous membrane of the tympanum is in a very irritable state."

I have thus attempted to give the principles of treatment advocated by men whose authority in aural surgery is universally recognized. From the study of the quotations I have made from these authors, and from my own observation during the past three years, I have come to place more and more reliance upon dry medication. If the ear can be *thoroughly, easily and painlessly* cleansed without the syringe, if there is no bad odor, if, after cleansing, inspection shows a large perforation in the membrana tympani, with a tympanic mucous membrane free from granulations, I

think we have just the condition which calls for dry antiseptic treatment. In such cases the insufflation of finely powdered, dry boracic acid often gives a prompt and permanent cure. If the perforation is small, especially if it is in the upper diameter of the membrane, the case will probably be troublesome. The difficulties are to establish drainage, and to medicate the tympanic mucous membrane. Various means are employed to accomplish these objects,—Politization, suction, the intra-tympanic syringe, enlargement of the perforation, etc. After cleanliness has been assured, I think that the saturated solution of boracic acid in *acute*, and alcohol in *chronic* cases give the best results.

If there is an offensive odor, it usually indicates the presence of masses of inspissated secretion in the recesses of the tympanic cavity. These should be softened by a solution of sodium bicarbonate and carbolic acid, (Politzer and Roosa) after which they can be removed by syringing. If now the mucous membrane is smooth, or shows only pin-point granulations, it should be thoroughly dried, and the dry powder be used. If the membrane is covered by granulation tissue, alcohol, nitrate of silver and tincture of iron are effective. If the granulations are large, the tympanic curette is a most useful instrument.

If suppuration continues after we have gotten rid of the granulations or reduced them to pin-points, the use of boracic acid powder frequently effects the cure at once.

When we have to rely on home treatment, the syringe and alcohol, or the saturated boracic acid solution (as administered by Politzer) seem to me the best remedies we can employ. In my own experience it is very seldom that we find an ear thoroughly cleaned by *wiping*, when the work is done at the patient's home. In the majority of cases I do not believe that the cotton ever reaches the bottom of the canal. I have been repeatedly assured that the ear was cleaned and that the discharge had ceased, and have found the tympanum full of bad smelling pus. On the



other hand there are very few people who cannot soon learn to use the syringe properly, if they are shown how to straighten the canal, and the syringing is done a few times before them. Vertigo is sometimes caused by syringing. This is especially apt to be the case if the stapes is exposed to the full force of the stream of water on account of the complete loss of the drum. In such cases all efforts to use the syringe should be abandoned.

In conclusion, I would urge the necessity of stopping treatment at the right time. As soon as the discharge ceases, all treatment should cease too. Relapses often follow attempts to make the perforation in the drum close or to improve the hearing. Nature is capable of doing a great deal toward accomplishing both of these objects, and I believe that we can help her most by doing nothing for several months after an otorrhoea has ceased.

## Selected Articles.

### CONDIMENTS.\*

BY WILLIAM A. HAMMOND, M.D.,

Surgeon-General U. S. Army (Retired List), Professor of Diseases of the Mind and Nervous System in the New York Post Graduate Medical School and Hospital, etc.

Condiments are those substances of an alimentary character which give piquancy or flavor to the food. Another effect which they possess is that of stimulating the action of the salivary glands and stomach by reason of their irritating qualities. Though of doubtful or low status as aliments they are yet extremely useful by making the food more savory by promoting digestion or by acting as agents for the development of nervous force. The principal condiments are pepper, cayenne, mustard, horseradish and vinegar. Salt may in some of its relations be considered a condiment, but it is more important as an alimentary principal entering as it does into the composition of the tissues of the body.

The use of condiments is not altogether to be commended, although there is no doubt that when employed with discretion they are capable of being advantageous to the organism, especially in the direction of promoting the digestion of substances which would otherwise be slowly acted upon by the digestive organs. But it must be recollected that the continual use of irritants is always eventually productive of debility in the tissue to which they are applied. In the case of the condiments mentioned, the disturbance produced when they are employed in moderation is scarcely appreciable and is more than counterbalanced by the good effects which follow. But if used in excess irritation and inflammation of the parts with which they immediately come in contact may be excited, but distant organs are often injuriously affected.

It is very easy to demonstrate the action of condiments in increasing the amount of saliva and gastric juice secreted. In regard to the first it is a matter of common experience that those substances capable of affecting powerfully the nerves of taste, cause an augmentation of the quantity of the saliva, and the same fact is readily proved by experiments on the lower animals, as for instance, the dog has been done by Bernard and others. It is, however, a more remarkable fact, and one which shows the intimate sympathetic relation existing between the several functions concerned in digestion that whatever increases the amount of saliva secreted, likewise increases the quantity of gastric juice. This can be readily shown by putting any strongly sapid substance, as for instance, mustard, in the mouth of a dog in which a gastric fistula has been formed. In a few seconds the gastric juice will run from the fistulous opening in the stomach, although no part of the mustard may have been swallowed.

I have alluded to the power of condiments in rendering the food more savory than it would otherwise be; when they exercise this influence they act as promoters of the appetite and thus cause us to eat more than we otherwise would;

\*From *Journal of Reconstructives*, July, 1886.

they rarely produce this effect with persons of naturally good appetites, their action being more strongly manifested in those who from some cause or other are not disposed to eat as much as the system requires. A bed-ridden woman, for instance, cannot eat a piece of roast-beef without great repugnance, and sometimes not at all, unless she can put a little French mustard upon it or accompany each morsel with a modicum of horseradish. One of my patients, a lady of delicate constitution, rarely ate any breakfast, and was therefore weak and unfit for mental or physical exertion all through the morning; until, at my suggestion, she spread the piece of toast or bread and butter that she could not eat, with aromatic mustard. This roused her latent desire for food, it stimulated her secretions, improved her digestive powers and gave her the fuel that her body required for its morning's work. I have frequently known persons sit down to the dinner-table with repugnance to all the articles on it to have their feelings entirely reversed at the sight of a pot of horseradish or freshly-mixed mustard. They knew by experience how these substances would spur their languid appetites.

It is rarely the case that sufficient attention is given to the use of condiments in the sick-room, they are often either altogether excluded, or the patient is allowed to take them at his discretion, whereas much benefit will frequently be obtained by the judicious employment of these important agents. In certain low fevers of typhoid type, and in almost all malarial disorders, condiments may be largely used with advantage. Probably no one of them is more generally efficacious than black pepper. Mustard is also frequently relished, and we all know how grateful to us in our illnesses a little vinegar has been. In inflammatory affections of the stomach and bowels the stronger condiments, such as pepper, cayenne, mustard and horseradish are seldom admissible, but many cases of diarrhoea are very decidedly benefitted, especially when they occur in persons who have somewhat run down in general health by black pepper, cay-

enne or mustard taken in quantities far above those which a healthy person would be likely to ingest. I have frequently known severe cases of diarrhoea to be cut short by a few doses of twenty or thirty grains each of cayenne, taken either in a little water or syrup. Black pepper is well known to be a remedy of no mean power in the common fever and ague of this country; it will often cut short attacks with as much promptitude as would large doses of quinine.

Cayenne appears to be particularly useful in nervous dyspepsia in which there is an atonic condition of the stomach and a tendency for the food to ferment instead of undergoing digestion. It is also especially beneficial when used with those foods of a vegetable character, which are not ordinarily digested without the evolution of large quantities of gas. Whether this gas comes from the food or from the patient it is not definitely known, but no matter what its origin its evolution is prevented by cayenne.

These then appear to be some of the chief advantages attendant on the use of condiments, and they are such as entitle them to rank high in the scale as accessory articles of food.

CARL BRAUN'S TREATMENT OF PUERPERAL SEPSIS.—Prof. Carl Braun has recently adopted a mode of treatment in cases of puerperal sepsis which has generally proved most efficient. As soon as a marked rise in temperature occurs the interior of the uterus is thoroughly curetted and disinfected by antiseptic fluid, usually thymol. The curette removes masses of decidua, blood-clots, and often pieces of membrane the presence of which would not be suspected, as the labor may have been normal. To be efficient, the operation must be done thoroughly yet gently, and when so performed the temperature has often fallen several degrees and in a short time become normal, and a normal lying-in period ensued. An iodoform pencil or uterine suppository is often placed in the cervix after the operation, and antiseptic gauze in the vagina to absorb discharges.—*Med. News.*



### Abstracts and Extracts.

TREATMENT OF TYPHOID FEVER.—Dr. F. Peyre Porcher, of Charleston, S. C., read a paper on this subject before the Association of American Physicians, from which we make the following abstract:

He described a method of treatment which he considered very satisfactory. As in all cases of high temperature there is costiveness, the result of the arrest of the intestinal secretions, he recommended a mild laxative at the beginning of the treatment. The following combination is useful:

R<sub>y</sub>. Rhei pulv., - - gr. ii-iv;  
 Magnesia, - - gr. x;  
 Hydrarg. chloridi mite gr. ss-ii;  
 Sodii carbonatis, - gr. iv;  
 Pulv. ipecac, - - gr. ½.

M. et ft. pulv. No. 1. Sig: One powder every four or five hours as required.

In the treatment of typhoid fever three things are to be considered; the necessity for maintaining the strength of the patient, the support of the system by the use of stimulants, and the morbid effect of high temperature. Special attention was directed to the latter element of the treatment. In reducing the temperature the speaker had resort to the use of ice-cold water, which was applied to the head, hands, and arms by the use of towels wrung out of the water and reapplied as frequently as necessary. The applications are continued for ten to fifteen minutes, until the heat of the skin is reduced. The use of baths was considered objectionable on account of the difficulty of their application and on account of the prejudice against them. He prescribes for internal use a fever mixture prepared thus:

R<sub>y</sub>. Potassii acetatis, - 3i;  
 Liquor amonii acetatis, - 3i;  
 Spr. etheris nitrosi, - 3ss;  
 Tinct. aconiti, - 3ss;  
 Aquæ ad, - - 5iv.

Sig: A dessertspoonful in a little water every two hours so long as the fever continues.

Morphia or the bromides may be added to the above preparation. It may also be employed in other fevers. Hot pediluvia may also be employed. Later the mineral acids are added. With reference to the use of stimulants, these may be continued as long as the tongue is dry. Oil of turpentine is often called for on account of tympanitic distension of the abdomen. It is also of value as an astringent and as a general stimulant. The speaker had treated thirty cases in private practice in this manner. Three died. In these cases there were causes sufficient to explain the fatal termination.

Dr. James Tyson, of Philadelphia, described a case in which, to reduce the temperature, he wrapped the patient in a sheet which was kept constantly wet with ice-water. This was entirely successful. In this case both antipyrin and thallin were employed; but although they promptly reduced the temperature, it soon returned to its original position. When it is necessary to keep the temperature continuously reduced, he considered some modification of the cold pack the best method.

Dr. James T. Whittaker, of Cincinnati, remarked that we should not lose sight of the possibility that the high temperature may be nature's way of getting rid of the poison. It has been found that the virulence of the typhoid fever bacillus can be reduced by heat. It is also possible that the changes formerly attributed to heat may be due to bacilli.

Dr. E. Darwin Hudson, of New York, said that when he assumed his duties at the Bellevue Hospital he found a simple and successful plan of treating typhoid fever in vogue. He was confident that under that treatment the successes among the pauper patients in that institution are greater than among the private practice of many physicians. The treatment is almost negative, consisting in sponging the patient every two hours during the continuance of the temperature above 102.5°, and adherence to an absolute milk diet. The only other measures employed are those directed to the relief of special symptoms occurring in the course of the disease.

Dr. Samuel C. Chew, of Baltimore, had employed with success quinia by hypodermic injection in order to reduce the temperature. It seems to have almost a specific action when used in this way. He used a solution of the hydrobromate, in which 20 mims represented 4 grains of the drug.

Dr. William H. Draper, of New York, remarked that there is perhaps nothing more fallacious than statistics in typhoid fever. Cases of fever not truly typhoid are confounded with typhoid fever. All have seen cases in which there was a continued fever, but in which the temperature did not run the typical course. In such cases we have no evidence that they are cases of typhoid fever. Experience shows that the value of antipyretic treatment in typhoid fever may be readily overestimated. In the majority of cases the value of antipyretics is not so much in reducing the mortality as in affording comfort to the patient. That it does do this, no one can doubt. The mortality of typhoid fever in the majority of cases depends upon conditions over which a reduction of the temperature would have no influence.

Dr. William Pepper, of Philadelphia, said that we have statistics showing the normal course of typhoid fever, which would make us slow to accept a mortality of 15 or even 10 per cent. as evidence of much success. He thought it doubtful if the normal mortality would be over 15 per cent. under good nursing. Successes vary. He had treated a series of 104 cases without a single death, and again he had treated 20 cases and lost 5. It is evident that in typhoid fever we have different sorts of fevers, and a remedy applicable to one set of cases may not be to another. An excellent rate of mortality may be secured by absolute rest from the first moment of suspicion, and a rigid diet of milk or milk diluted. In addition he believed that the abstraction of heat is of great value. He thought that some remedy directed to the constant and important lesion of typhoid fever aids in reducing the temperature. His own preference is for the salts of silver. If the case comes under observation early, is put at absolute rest,

receives proper treatment, the mortality should not exceed 5 or 6 per cent. In private practice he believes that it can be kept down to this.—*Amer. Pract. and News.*

DR. GALLARD'S CLINIC FOR DISEASES OF WOMEN AT THE HÔTEL-DIEU. — Dr. Thomas Linn, in the *Medical Times* says: The very large number of patient's treated, and the fact that Dr. Gallard is the most prominent of the specialists of women's diseases in Paris, lead us to give copies of a few prescriptions in the most common forms of disease met with here. It may be stated that so frequent is the demand for these formulas that the doctor had them printed all ready for use. Even his signature is lithographed.

The following is given in all cases of *metritis* or in *anæmia*:

1st. R Ferri subcarbonat., 10 grms;  
Ext. cinchonæ (soft) 10 grms;  
Ext. opii aquos., 1 gramme. M,

Divide into one hundred pills. Not to be silvered.

2. Drink iron-water at meals. To be made by putting a few iron nails in common water.

3d. Take every week two sulphur-baths, or every morning take a shower-bath of fifteen seconds.

4th. Take at the noon meal every day a wine-glass of cinchona-wine.

5th. Take once every week thirty centigrammes of powdered rhubarb at dinner (last evening meal).

The next one is given in all cases where a *uterine fibroma* has been found:

1st. R Extract. hyoseyami, 3 grms;  
Plumbi iodid., 6 "  
Adipis, 50 grammes. M.

Sig.—Every evening use this pomade by friction on the abdomen.

2d. In the morning wash it off with soap and water.

3d. Twice a week stop these frictions, and use instead tincture of iodine painted on the abdomen.

4th. Take every day a teaspoonful of this solution:



R Potassi iodidi, 10 grms;  
Aquæ destillatæ, 250 grms. M.

5th. Twice a week take a salt-water bath, and daily use very large vaginal injections of fresh water.

6th. Support the viscera with an elastic abdominal belt.

In cases of *cancer of the uterus* the following is given :

1st. R. Conii fructus pulveris,  
Ext. gentianæ, āā 3 grms.  
Ext. opii aquos., 60 centigrms.

Divide into sixty pills. M.

Sig.—Take one every morning.

2d. Apply on the belly cataplasms of laudanum, as needed, for pain.

3d. Use twice a day an injection of water in which for every pint add a tablespoonful of

R Acid. carbolic. (crystal), 10 grms.;  
Alcoholis, 250 grammes. M.

Or else add half a teaspoonful of this: Perchloride of iron (solution Pravaz) at 30°.

In all cases of women also having *phthisis* the following directions are given :

1st. R Sodii arseniatis, 10 centigrms;  
Aquæ destillatæ 250 grms. M.

Sig—Take a teaspoonful with every meal.

2d. Use as a drink an infusion of pectoral flowers, to which add syrup of tolu.

The French infusion of pectoral flowers consist of mallow, coltsfoot, catsfoot, red corn, rose or poppy, guimauve or marshmallow, etc.; and it might be remarked here that while the practice of the French physicians of giving infusions of herbs may seem to us old-fashioned, still it is wonderful to see what relief they often afford to patients.

3d. Take every evening, at least two hours after the last meal, a pill containing ten centigrammes of *cynoglossum*.\*

4th. Paint every evening one-quarter of the chest with tincture of iodine, in such

a way that you do not paint over the same place more than once in four days.

With the above internal treatment, Dr. Gallard uses the usual local application *per speculum*, once a week, that are in use by gynecologists.

THE BACILLI OF TYPHOID FEVER.—Dr. Vilchur, who has been engaged in studying the bacteriology of typhoid fever in Prof. Alanasieff's laboratory, and who has published an interesting communication on the subject in the number of the *Vruch* just to hand, finds that typhoid colonies are generally larger than similar colonies of a non-typhoid character; their color, also, is a yellowish cinnamon, where as in others there is no yellow tinge, and, moreover, they are cinnamon under circumstances in which non-typhoid colonies turn of a brown or even of a black color. In doubtful cases consideration of the symptoms and of the microscopical preparations of the colonies will generally serve to distinguish those of a typhoid origin. Dr. Vilchur made more than two hundred cultivations from the organs of four typhoid patients, and examined the stools of twenty cases about the thirteenth day of the disease. He found that the bacilli multiply more luxuriantly in meat-peptone agar-agar than in meat-peptone jelly. Their breadth seems, too, to depend upon the cultivation medium, the broadest being developed on potatoes at 27° C., and the narrowest in meat-peptone agar-agar at the ordinary temperature of the room, the length ranging from the third of the diameter of a red blood-corpuscle to more than the full diameter. The longest specimens were developed in jelly cultures, and the shortest in agar-agar ones. Peculiar forms were met with after jelly cultures had stood for a considerable time; some bacilli being unequal in width, others having spores at the extremities and taking the stain very badly. Spores that could not be stained were obtained after a potato culture had remained in the thermal chamber at 37° C. for forty-eight hours, or for from fifty-eight to sixty hours at 27° C. When the potato remained for from seventy-two to

\*The pill of *cynoglossum* used in Europe usually contains opium, to which its therapeutic effects are probably due.—Ed. P. M. T.

eighty hours at 37° C. the spores regained the ability to take the stain, and indeed stained better than the bacilli themselves. An excellent stain for the purpose was found to be a solution of rubine in aniline water. In potato preparations kept for from forty-two to sixty hours bacilli were frequently met with presenting entirely unstained portions or vacuoli, the rest being well colored. The author remarks that the micro-organisms which grow in colonies on plates do not correspond in number with those met with in stools, which implies that peptone jelly and agar-agar are not suitable media for the development of all micro-organisms. The stools of typhoid patients almost always contain typhoid bacilli in greater or less numbers and capable of being multiplied by cultivation. In the present series of researches they were found in sixteen cases out of twenty; in one case of typhus levis and in one of typhus afebrilis the existence of typhoid bacilli was demonstrated quite clearly.—*Lancet*, July 17, 1886.

**ELECTRIC BATHS IN EYE DISEASES.**—Prof. Denti, writing to the *Annali di Ottalmologia*, states that he has found electric baths and douches very valuable in several ophthalmic affections, especially in those which refused to yield to more ordinary methods of treatment. His apparatus consists of a vessel of water placed at a height of two metres above the patient's head, a constant current battery of thirty-cells, and a glass or ivory box without a bottom. This box is fitted onto the eye. It contains a metal pipe communicating by an india-rubber tube with the water vessel, from which the box can be filled with water; an efferent non-metallic pipe is also provided. The metal pipe is connected by wire with one pole of the battery, the other electrode being placed on the forehead or crown of the head. The sittings are of from four to six minutes' duration. For baths eight or ten cells are used, for douches twenty or more. No unpleasant effects have ever been observed, the stimulating action being only sufficient to produce a slight degree

of hyperæmia. The author finds that the baths are best in deep-seated affections, such as those of the vitreous or of the optic nerve; the douches are useful in more superficial affections, such as those of the conjunctiva and cornea. Dr. Denti tried the electric baths in six cases; four of atrophy of the papilla in different stages, one of disseminated cloudiness of the vitreous, and one of double ulcerative blepharitis. The papillary atrophy was benefitted most when it was slightest. In one case of atrophy accompanying disease of the spinal cord, the intra-ocular affected was, or appeared to be, arrested. The patient with the cloudy vitreous was so much improved that, though at first he could scarcely distinguish large objects, after thirty sittings he was able to read ordinary print. The patient with blepharitis was completely cured. The douches were employed six times; in three cases of paralysis of the eye muscles, and in three of exudations remaining after ulcerative keratitis. One of the cases of paralysis was entirely cured, the other being improved; and in the cases of keratitis the success was most marked, the exudation being completely absorbed.—*Lancet*, July 17, 1886.

**NATURE AND CAUSE OF INTERNAL ROTATION.**—Dr. D. Berry Hart thus formulates a law governing the internal rotation of the fœtus:

1. Whatever part of the foetal head or trunk first strikes a lateral half or lateral part of the sacral segment is rotated internally to the front, and in the direction opposite to the lateral half or lateral part of the segment so acting.

2. No part of the fœtus is ever rotated directly into the hollow of the sacrum. The passage of the occiput into the hollow of the sacrum in its so-called posterior rotation is exactly equivalent to the passage of the sinciput into the hollow of the sacrum in normal rotation and should be excluded from descriptive terminology, as the latter is.

3. The direction of rotation may be predicted in any case by noting what part first strikes a lateral half of the sacral segment.



This view of rotation gives, in my opinion, a more coherent idea of all the rotations than those based on the shape of the head or pelvis only. I do not deny the influences of the shape of the internal surface of the pelvis, but I deny that it alone can determine rotation.

It seems to me, also, that we here see an explanation of the pelvic inclination, Roederer's obliquity, Solayres' obliquity, and the general shape of head and body of foetus.

The pelvic inclination, as we term it, gives us, by its slope, a short anterior pelvic wall, and may be looked on as due to a slicing away, as it were, of part of the anterior pelvic wall. The kidney shape of the brim, such that the head there does not fully occupy it and lies with the Solayres' obliquity, is necessary for the distention of the bladder during pregnancy; while the shape of the occiput, chin, neck, and sternum allows of Roederer's obliquity in head cases, or extension in face cases, so as to make a part, either occiput or chin usually lead during labor. The short anterior pelvic wall and oblique and deep position of a part of the foetus (occiput, chin, breech) being necessarily the fetal part lying anteriorly at the brim early within the reach of a lateral portion of the sacral segment—that is, tend to cause its early rotation.—*Edinburgh Med. Journal.*

**HYDROPHOBIA**—Dr. Vincent Richards writes to the *Lancet* (June 26, 1886) "I should like, with your permission, to offer a few remarks regarding Surgeon-Major Pringle's paper on the above subject which appeared in your issue of April 24th, 1886. Is it not possible that the author attaches too much importance to the suction of the wound, and too little to the incisions which were made? It seems to me that free hæmorrhage is a very considerable safety-valve in the case of a bite by a rabid animal; so much so, indeed, that I believe it is good practice, in wounds that are punctures, to incise them, with a view to the encouragement of bleeding, which expels some of the virus, and to facilitate the

application of a caustic. I believe it would be a most dangerous precept to condemn cauterisation in the bites of rabid animals. The procedure I have for some time advocated is the following: The wounds should be most thoroughly washed out—deep wounds by means of a syringe—with a warm weak solution of permanganate of potash; punctured wounds being first incised, and bleeding encouraged. After this has been done, each wound should be carefully wiped, and powdered permanganate of potash rubbed into it. When the wounds are deep, injections of a 5 per cent. solution of permanganate should be had recourse to. Now, what are the objects of this treatment? They are (a) to cause the expulsion of as much of the virus as possible; (b) to neutralize any virus that may remain, and (c) to cauterise the part so as to convert it into dead tissue, which, as we know, is incapable of performing the process of absorption. I advocate the use of the permanganate of potash, because I know from practical experience that it has the effect of rendering snake poison,—which appears to be allied to rabic slaver—quite inert. Under any circumstances, I hold that incision, and, in cases where the wounds are ragged, excision, the neutralization of the virus, and the cauterization of the parts are the measures which are the best calculated to prevent the absorption of the virus into the general system.

I do not propose here entering into a discussion of the merits of M. Pasteur's method; but I cannot help saying that there appears to exist an unreasoning acceptance of assertions in favor to the exclusion of facts which are unfavorable. So far as I can gather, the very essentials of proof on scientific grounds are wanting. There is nothing whatever to show that the numerous persons being inoculated at his laboratory were bitten by rabid animals, if we except the fatal cases; nor is there anything to show how far immunity from rabies may have been due to causes other than those claimed by M. Pasteur. Nor has sufficient time elapsed in any given case to warrant the assumption that the period of incubation has yet passed."

VAGINAL SECRETIONS, THE REACTION OF, IN HEALTH AND DISEASE.—Dr. P. Ménière finds that, contrary to the opinion of Dr. Martineau: (1) The fact of the vaginal secretions being acid does not prove at all that they are not specific. (2) That it remains to be proved that alkaline secretions are ever found coming from vulvo-vaginal inflammations. (3) Secretions having an acid reaction may be caused by a transformation of pus, a transformation known to take place on the surface of wounds and consequently dependant upon the blenorrhagic inflammation. The doctor ends his pamphlet with the following conclusions:

1st. The human organism is essentially alkaline.

2d. Woman is less alkaline than man.

3d. The vulvo-vaginal secretions tend to become more acid as the constitution becomes more debilitated.

The uterine secretions, under the same circumstances, become less alkaline.

In health there is a slight acidity of the vulvo-vaginal secretions (with the exception of that of the glands of Bartholini) and a slight alkalinity of the uterine secretions.

4th. The changes of composition are proved by: Clinical facts, chemical analysis, microscopical examination, and particularly by the fact that certain thermal springs will cure sterility due to this acidity.

5th. Whatever the changes in composition.

The mucus secreted by the vaginal mucous membrane always preserves an acid reaction.

The mucus from the cervix and body of the uterus and that of the vulvo-vaginal gland remains invariably alkaline.—*Archiv. Gynæcology.*

AN INFINITESIMAL ORGANISM.—In order to give the student of micro-organisms an idea of the extent to which such a path of research may lead him, there should be set before him the investigations recently made by Rev. Dr. Dallinger, president of the English Microscopical Society, as disclosed in a lecture entitled "The Latest work among the

Least and Lowest Forms of Life," given by him at the First College, Sheffield, England. In it he described the result of three years' close study with the minutest form of life. He stated that he has now microscopic lenses which only five years ago were declared by mathematicians to be impossible of accomplishment. By means of these he demonstrated to his audience shells in a piece of chalk of which it would take four million to make an ounce. In a drop of water he could show a desmid which measured only one millionth of a cubic inch; but this was a giant compared to the smallest organism known, of which within the last few months he has made the discovery and found that the flagellum or motor fibre of this infinitesimal entity is two hundred and four millionth seven hundred thousandth of an English inch. One is awestruck at such a discovery as this, and it is a question as to which should incite an admiring amazement the most, the minuteness of the organism or the mighty mind that can comprehend it and mathematically demonstrate it. Such a great discovery as this, the smallest known organism, will settle any restless feeling of a scientific Alexander, if such can exist, by showing him that he need not for a long time to come sigh for new worlds to conquer.—*Medical Record.*

THE PHENIC-ACID TREATMENT OF PHTHISIS.—In the modern treatment of phthisis there is about an equal activity among those who are urging antiseptic and those who are urging supporting medication. Pulmonary injections, inhalations, forced feeding, rectal feeding, dry or compressed, and medicated air are among the measure that are receiving attention.

M. le Dr. Filleau (*Jour de Médecine de Paris*) believes phthisis to be a parasitic disease, and one to be combated by anti-parasitic remedies. Of these, the most potent against the bacillus and injurious to the human system is pure carbolic acid. This he does not think should be applied topically, but rather should be given internally. Carbolic



acid, he says, is largely excreted by the lungs, and in its passage out the parasite's activity is suppressed and the healing process promoted.

He recommends that the acid be administered hypodermically and in considerable experience has never seen any harmful or unpleasant local symptoms develop. His formula is:

R. Aquæ destillat.	95.00
Glycerin.	q.s
Acid. phenic. crystalliz.	1.00

M. Sig.—Of this, one hundred drops (about gr. ij. of acid) are injected hypodermically daily, or every other day.

Dr. Filleau states that as much as two grammes of carbolic acid can be administered daily, a dose which would require a very large number of injections. Four cases are reported illustrating the efficacy of this phenic-acid treatment of phthisis. The conclusions reached are: 1st, that carbolic acid is the only antiparasitic as yet known that can be administered subcutaneously in large doses during an indefinite time without causing accidents; 2d, that under the influence of this medication the general state is at the same time advantageously modified; 3d, that the tolerance and harmlessness of the drug thus administered (symptoms of carbolic-acid poisoning may appear, but they always come gradually and are quickly relieved by stopping the medicine for a time); 4th, that the treatment must be continued for a long time.—*Journal of Reconstructives*.

FREQUENCY OF DISEASE OF THE UTERINE APPENDAGES.—In a paper on this subject (*American Journal of Obstetrics* June, 1886.) Dr. H. C. Cox, of New York, draws the following conclusions:

1. Ovarian disease is *not* as common as it has been represented; the surgeons and *not* the pathologists, being responsible for the prevalence of the contrary opinion.

2. Because an ovary is partially diseased, it does not follow either that its functions have been materially impaired or that its removal is imperative.

3. The expressions "cirrhosis" and

"cystic degeneration" commonly applied to the ovaries are mischievous terms, which are too often used in justification of *unjustifiable* operations.

4. Actual disease of the tubes is far less frequent than is generally believed. Lesser degrees of inflammation, especially slight "catarrhal salpingitis," are seldom appreciable to the pathologist, still less to the surgeon.

5. Many of the symptoms ascribed to disease of the uterine appendages are really due to *localized peritonitis*, and will *not* be removed by a removal of the appendages.

6. The physiology of the ovaries and tubes is still imperfectly understood; their pathology must then remain *sub judice*, and operations for their removal on the ground of limited disease alone, must be regarded as largely empirical. To which I would venture to add the prediction:

7. The present enthusiasm in this country in favor of Tait's operation will not endure, because it will eventually be discovered that the number of *permanent* cures is entirely out of proportion to the number of operations.

#### ANTISEPTIC TREATMENT OF CROUP.—

The following is a plan of treatment recommended by M. Renon (*Journal de med. de Paris*). The patient is placed in a well-ventilated room of medium size, the temperature of which is maintained at from 68° to 75° F. Upon an oil-stove is kept a vessel, of a capacity of two quarts, in which the water is constantly boiling. Into this put, every three hours, a tablespoonful of a mixture of salicylic acid, 56 parts; benzoic acid, 112 parts; carbolic acid, 280 parts; and alcohol, 468 parts. The stove is placed near the bed, and the steam impregnated with this mixture is conducted, by means of suitably arranged curtains, to the patient. The patient is kept in this atmosphere until the symptoms have entirely disappeared, and for two or three days after; and, if tracheotomy has been performed, until the wound is closed. A close watch should be maintained over the case, and if any symptoms of poisoning are manifested, the quantity of carbolic acid should be diminished.

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## Editorial.

A HISTORICAL SKETCH OF THE DISEASE ACTINOMYCOSIS.—The term actinomycosis, according to its present acceptation, no longer signifies a disease alone affecting cattle, but is applicable to a similar pathological process that is demonstrated to be communicable to the human being as well, and whose seat of infection, beside being in the mouth and pharyngeal cavity, may be found in the respiratory and intestinal tracts, and in wounds of the surface of the body. It may be said that in gross the naked eye changes resulting from the presence of the "ray fungus," the etiological organism of this disease, resemble those seen as the consequence of tuberculous and syphilitic infection.

The first observations on the "ray fungus" were made by B. Von Langenbeck, in Kiel, in the year 1845. He found in the contents of abscesses in two human beings structures in every way identical to that we now know under the name of actinomycosis. At that time he made notes and drawings of this observation, but they were withheld from publication until 1878, when they appeared in J. Israel's article "*Neue Beobachtungen auf dem Gebiete der Mykosen des Menschen.*" (*Virchow's Arch.*, Bd. 74).

In June, 1877, Bollinger published in the *Centralblatt für d. med. Wissenschaften* a brief but excellent description of the disease then known as "swell head," "lump jaw," "wooden tongue,"

which was supposed to be primarily an osteo-sarcomatous process beginning usually in the lower jaw of cattle. Following the suggestion of the botanist Harz, Bollinger introduced the name actinomycetes for the parasite. As discoveries are reckoned from the date of their first publication, Bollinger is to be regarded as the discoverer of the parasite and the disease produced by it, although there is no doubt that the same parasite was observed by B. Von Langenbeck in 1845.

In 1878 J. Israel published his observations of a parasite (which was undoubtedly identical with that described by Bollinger) in abscesses in two human beings. At the time of his publication Israel was not aware of Bollinger's observation, and therefore did not recognize the identity of his parasite with that first described by Bollinger. Israel regarded his organism as a streptothrix.

In April of 1879 Ponfick, who had studied the organism described by Bollinger, found in the pus of a prævertebral phlegmon in a human being, the "ray fungus," and at once recognized its identity with that described by Bollinger. On April 19, 1879, he demonstrated the fresh specimen before the Surgical Congress then held in Berlin.

While undoubtedly Israel's observations related to the disease actinomycosis, Ponfick was the first to clearly recognize the identity of the process as it occurs in man with that in cattle first described by Bollinger under the name actinomycosis.

In 1883, at the instance of the Commissioner of Health of Chicago, Dr. W. T. Belfield undertook to investigate the disease then prevalent among the cattle herds of the neighborhood, and which was known under the name of "swell head," "lump jaw," &c. The result of his investigations was that he was enabled to establish the identity of this affection with the actinomycosis described by Bollinger. It is to Dr. Belfield, of Chicago, that the credit of having first discovered the disease in this country is given.

In 1884 Johne, in "*Beiträge zur Ätiologie der Infections-geschwülste*" (*Bericht*



über das Veterinäreveessen im Königreich Sachsen) records the observation—that actinomycosis may appear in the horse, and develops usually as a chronic thickening of the spermatic cord. He thinks the organism gains access during the process of castration, as it was in castrated animals that he discovered the organism. Out of fourteen cases of thickening of the spermatic cord in the horse, he demonstrated the actinomycotic nature of the disease in three. In a fourth case of chronic funiculitis in the horse, he describes an organism as the cause of the disease, whose description is not similar to that usually given for the actinomyces, but simulates more closely that given by Billroth for his "askakakkus." He thinks this to be identical with one of the degeneration forms of the organism described by Rivalta, under the name "discomeciti patogeni." In a later publication Johnne describes three additional cases of chronic thickening of the spermatic cord in the horse, in which he found the actinomyces.

His observations lead him to conclude with Ponfick that beside the alimentary and respiratory tract the organism may gain access to the system through wounds of the surface of the body.

Beside the above publications numerous other contributions upon this disease have been received, the more prominent among the number being two very exhaustive monographs—one by Ponfick and the other by J. Israel. These publications bear more especially upon the disease as occurring in man, giving the pathological appearances and clinical history of a number of cases.

Israel has collected in all 38 cases of the disease in man; this number includes all those previously reported. He has carefully studied these cases and has divided them in four groups depending upon their different points of inoculation.

Under Group 1 he classes all those cases in which the organism gained entrance into the system through the mouth or pharyngeal cavity.

Group 2 contains those cases of primary actinomycosis of the respiratory apparatus.

Group 3 comprises all those cases in which the intestinal tract was the point of primary infection.

Group 4. Under this head he places all cases where point of infection cannot be definitely made out.

Of the 33 cases reported by Israel, 17, or nearly half, could be positively claimed to have the mouth or pharyngeal cavity as the point of primary infection, the organism probably gaining entrance through a carious tooth or some erosion of the soft tissues. He was enabled to trace the primary point of infection of 9 of the 38 cases to the respiratory tract. Seven were made out to be primarily intestinal actinomycosis. The primary point of infection of the 5 remaining cases were not positively made out, but were supposed, as nearly as could be traced, that they were probably either the respiratory tract, the skin or the pharynx. They were therefore placed in group 4.

As stated above, Ponfick's first case of actinomycosis in man had its origin in a fistulous opening on the posterior wall of the œsophagus, extending along the anterior surface of the dorsal vertebral column and terminating in a prævertebral phlegmon in which unmistakable actinomycotic bodies were found.

In his second observation the characteristic masses of the parasite were demonstrated with much difficulty. After a long continued search he found in a recess on the posterior interior surface of the pleura masses of organisms without the club shaped hyphæ, but so sparsely that Ponfick spoke of it as a case of "actinomycosis without actinomyces." This case gave him the opportunity of renewing his original opinion—"that the actinomyces, in and of itself, was not a special pus exciter," for in this case there was no purulent matter in the pleural sac at the time it was punctured and the serous exudate only became purulent after the opening had been made.

The pathological changes brought about by this disease depend in a measure upon the locality of the infection, but in a general way it may be stated that the process begins as a tumor formation of

an elastic consistence. An incision into this growth at an early stage shows a reddish or pinkish discoloration with here and there small yellowish ponds, indicating colonies of the parasite. Throughout the mass we find bands of white fibrous-looking tissue. Later we have multiple abscess formations throughout the tumor with production of greater or less amount of pus and the establishment of sinuses and fistulous tracts. This may continue until the whole of the new growth is undermined and broken down. In the purulent material that is discharged from this affection we can detect with naked eye sulphur yellow bodies about the size of a small hemp seed. These represent the parasite as it occurs in the tissues.

In those cases in which the mouth cavity is the point of primary infection we have usually an enlargement appearing upon the lower jaw, with involvement of the lymphatic glands. This tumor has been supposed to simulate in its histological structure the osteosarcoma, but is now recognized as belonging to the great class of granulation tumors such as tubercle, gummy, etc.

When the disease has the respiratory tract its point of primary infection we may have a nodular swelling at the point of inoculation with a pneumonic inflammation around it which gives rise, in some instances, to symptoms closely related to croupous pneumonia. This central point of infection may break down into abscess cavities for which sinuses and fistulæ form communicating with the pleural sac and giving rise to the symptoms of empyæmia. A case is reported in which primary infection through the respiratory tract gave the symptoms of chronic bronchitis with purulent expectoration.

The prævertebral tissues are commonly involved, with the extension to the vertebral column and consequent destruction of the bones. The case referred to as demonstrated by Ponfick at the Surgical Congress at Berlin, was that of a prævertebral phlegmon with involvement of the dorsal vertebræ and fistulous formations through the muscles of the back. The ribs and sternum may be

affected and the parasite has been found in the muscles of the heart.

When the intestinal canal is the point of primary infection, the growth appears as an enlargement upon the mucous membrane. It differs but little in color, from the tissue in which it is located. Careful search will always reveal the sulphur-yellow masses of the parasite. Secondary to these we find the liver, spleen and post-peritoneal tissues involved. Excepting the presence of the characteristic sulphur-yellow bodies in the purulent material of these cases, the morbid changes very closely resemble those sometimes resulting from syphilis and tuberculosis.

The organism has hitherto been looked upon as a member of the class of mould fungi and was described as a mycelial formation having a central point from which radiate in a rosette-like manner hyphæ upon whose distal extremities appear bulbous enlargements. It is from this radiate arrangement that it derives its name—acteno-myces or "star fungus."

In mass, they appear in the tissues and in the pus from abscesses resulting from their presence, as small sulphur-like bodies about the size of a hemp seed. They are easily discernable by the naked eye, and a low lense will resolve them into their structure from which they derive their name.

Recent observations, however, by Baström (*Beilage zum Centralbl. f. Klin. Med. No. 20*) in which he has cultivated this organism, demonstrates that all previous notions concerning the nature of this parasite were erroneous. In his cultivation experiments he describes the organisms as growing into long pointed threads with at the same time the production of spherical or coccus forms. He concludes from this that the processes seen in the rosette-like structure of the parasite when examined in the tissue are not the outgrowth of normal development but are rather involution forms resulting from degenerative changes in the organism itself. He therefore decides that the parasite is not a common mould as formerly supposed but belongs to the class of Schizomycetes, and should be assigned to the clodothrix group.



### Book Reviews.

**BRIGHT'S DISEASE, AND ALLIED AFFECTIONS OF THE KIDNEYS.** By CHARLES W. PURDY, M.D., Professor of Genito-Urinary and Renal Diseases in the Chicago Polyclinic, Member of the College of Physicians and Surgeons of Ontario, etc., etc.

This book opens with a chapter on Albuminuria, giving a short history of the discovery of this most interesting pathological condition, and the various theories which from time to time have been adduced to explain its causation. There is an excellent resumé of the tests to ascertain the presence of albumen in the urine, with some strong common sense remarks on the subject of quantitative analysis. The author takes occasion to commend the very convenient test papers of Dr. Oliver.

Authorities, ancient and modern are quoted concerning the etiology of uræmia, the author very candidly leaving the question open. The remarks on the treatment of acute and chronic uræmia are practical and suggestive.

It is with pleasure that one notes the simple and rational division of nephritis into acute and chronic, instead of the confusing and useless sub-divisions generally given. The chapter on cirrhosis of the kidney is very good, especially the symptomatology and treatment.

The remainder of the book is devoted to certain conditions of the kidney which are met with as sequelæ of systemic affections.

Scarlatinal nephritis is discussed at length, with a chapter on amyloid kidney and another on cyanotic induration. The author gives we think a rather too distinctive place to puerperal nephritis.

Altogether the book is highly satisfactory, and after reading it one feels that it was needed. The subject is discussed in a simple, clear and concise manner and will be useful alike to student and practitioner. The pathology includes the most recent investigations, and under the head of treatment will be found all the newly discovered drugs that have proved useful in the urinary affections. The liter-

ary style of the book is most excellent, and we commend it to those about to write.

### BOOKS AND PAMPHLETS RECEIVED.

*Report of the Board of Managers of the Pennsylvania Hospital for 1886.* Collins, Printer, Philadelphia.

*Enucleation, with Transplantation and Reimplantation of Eyes.* By CHARLES H. MAY, M.D., Instructor in Ophthalmology, New York, Polyclinic, etc. (Reprinted from the *Medical Record*, May 29, 1886.)

*Annual Announcement of Trinity Medical School, Toronto, for 1886.*

*Annual Catalogue of the University of Maryland School of Medicine, Session 1886-87.* Prof. J. Edwin Michael, Dean, 246 Madison Avenue, Baltimore, Md.

*Annual Announcement of the Baltimore Medical College, Session 1886-7.* Prof. Wm. Lee, Dean, Corner Eutaw and Hoffman Streets, Baltimore.

*Annual Catalogue of Bellevue Hospital Medical College, New York City, Session 1886-7.* Prof. Austin Flint, Secretary.

*Permanent Drainage for Ascites.* By LLWELLYN ELIOT, M.D., Washington D. C. (Reprinted from the *New York Medical Journal* for June 26, 1886.)

*A System of Practical Medicine.* By American Authors. Edited by WILLIAM PEPPER, M.D., etc. Vol. V, Diseases of the Nervous System. Philadelphia: Lea Brothers & Co. 1886.

*The Genuine Works of Hippocrates.* Translated from the Greek, with a preliminary Discourse and Annotations. By FRANCIS ADAMS, LL.D. Vol. II. New York: William Wood & Co. 1886.

*Diseases of Digestive, Urinary, and Generative Organs.* Illustrated by 106 fine wood engravings. Being Volume II. of the Handbook of Practical Medicine. By DR. HERMAN EICHHOFF, Professor of Special Pathology and Therapeutics and Director of the University Medical Clinic in Zurich. This is Vol. VI. of Wood's Library for 1886. New York: William Wood & Co.

### Miscellany.

**EXTRACT OF CALABAR BEAN IN EPILEPSY.**—Dr. Rusche recommends the exhibition of calabar bean in epilepsy and allied affections, and says he found it to render great service in cases in which the bromides and atropine have been ineffectual (*Deutsche Medicinal-Zeitung*, May 10, 1886). He notes the curious circumstance that better results are obtained by alternately increasing and diminishing doses than when the same quantity is given continuously. The drug is to be given in the following preparation: Extract of calabar bean 7½ grains; spirits of sulphuric

ether, 75 minims; peppermint-water, 5 drachms. Dose: 5 to 10 drops for children, 8 to 16 drops for adults, three times a day. The smaller dose is commenced with the first day, and one drop added each day until the maximum is obtained, and then the quantity is diminished by a drop each day until the minimum is reached. The writer reports a number of cases in which excellent results were obtained.—*Med Record*.

A CASE OF RUMINATION.—Dr. W. A. Hubbard, of Bloomfield, N. Y., reports in the *Medical Record* the following case: D. L.—, farmer, aged thirty-five, of Irish descent, consulted me in April, 1885, for, as he expressed it, the restoration of his 'lost cud.' He had contracted the habit at a time beyond his recollection, and had had no intermission in its practice until one month previously, when it had suddenly ceased and was immediately followed by dyspeptic symptoms. He had constant nausea, although vomiting he found to be impossible. It had been his habit to swallow his food hurriedly, with as little mastication as possible, and retired from his family or associates, after which the process of regurgitation immediately began and continued for the perfect digestion of the food. He had been an enormous eater, and his health had been perfect until the sudden stop in this peculiar physiological process occurred. I informed him that his request was undoubtedly unique, and suggested the thorough mastication of his food previous to deglutition; but this, owing to habit and forgetfulness, seems impossible, and he still continues dyspeptic, despite the usual remedies given to aid digestion, and lives in the expectation that his habit will return as suddenly as it left him.

RADICAL OPERATION FOR HERNIA.—An improved operation for the radical cure of hernia has for some time past been practised by Drs. Svensson and Erdmann, surgeons to the Sabbatsberg Hospital at Stockholm. A ligature is applied to the neck of the hernia, and the sac is cut off below the ligature, the contents

being previously examined by means of an incision into the sac and returned; or, if only omental, excised together with the sac. In congenital hernias the upper part of the sac only is removed, and where the large bowel is included in the hernia and adherent to the sac wall, this, after being separated from the surrounding tissue, is returned, together with the large intestine, and the rents of Poupart's ligament united by sutures. The dressing employed is iodoform and boric acid, the wounds being washed with sublimate solution. Since this has been substituted for carbolic gauze, abscesses which used to occur frequently, have become rare. Of the forty-eight cases thus operated on, none of which were selected, thirty-eight were permanently cured—at least no return of the hernia occurred within six months; and in the cases where a return did take place, which amounted to 20 per cent., the condition was very much less painful and distressing than it had been previous to the operation. The Sabbatsberg Hospital has now been open six years and a half, and during that time 300 cases of hernia have been admitted, and about 300 of these being operated on with the knife; a milder procedure, consisting of alcoholic injections, being employed in most of the earlier cases. Not a single case proved fatal, though some of the hernias were very large, some reaching within three or four inches of the knee.—*Lancet*, June 26, 1886.

SWIMMING A COMPULSORY STUDY.—The sad recital of deaths from drowning which have occurred at various parts of our coast during this summer may well impress upon us the need, too little regarded, that every capable member of the community should learn to swim. We have already commented upon this subject, and have gone so far as to advocate the inclusion of swimming as an essential branch of education. Some, perhaps, may think that our view is an extreme one; they may tell us that fatalities from drowning do not, after all, greatly swell the registered death-rate, unless, indeed, we include those due to shipwreck, and that physical education



may be regarded as an optional form of training, for which taxpayers would object to become responsible. From such a line of argument we feel obliged to differ. When we consider how great a portion of our population live at the coast, how many of these follow a seaman's calling, to what exigencies even the dwellers in inland districts may be exposed, and are often fatally exposed, by the chances of an occasional sea-voyage, or by the customary visit to the seaside, it appears to us at least highly expedient that swimming should be included in the compulsory school course. It must be remembered that the time or trouble involved in teaching this art is as nothing in comparison with that required for intellectual study. The further steps of practice proceed without tuition. Admission to baths is not costly; the habit acquired is never lost, and the gain is invaluable.—*Lancet*, July 17, 1886.

**TRAUMATIC TETANUS TREATED BY REST.**—Dr. De Renzi states, in the *Rivista Clinica*, that by treating patients with traumatic tetanus by means of perfect rest he has been able to restore four out of five to health; whereas when treated in other ways these patients usually die in two or three days. He places the case in a special room where absolute silence reigns. Even in the passages leading to it and in the neighboring wards care is taken to lay down carpets so that no sound shall penetrate the tetanus ward. The door of the latter is, of course, well oiled, so as to open and shut noiselessly, and the patient's ears are stuffed with cotton-wool, he himself being strictly enjoined not to make the slightest noise. He must, of course, be fed. This has generally been considered impossible, the teeth being clenched and the spasmodic contraction being increased by attempts to masticate. The obstacle may, however, be easily overcome by parting the jaws and introducing liquid food through a curved sound, swallowing is accomplished without difficulty. This method of treating traumatic tetanus has been tried with success by several Italian practitioners—

Drs. Pisani, Maragliano, Ria, &c. The only disadvantage is that the affection is sometimes prolonged for two months. It seems to increase in duration as it diminishes in force.—*Lancet*, July 10, 1886.

**"HOT EYE" IN ASSOCIATION WITH GOUT.**—Mr. Jonathan Hutchinson, in a note on this subject, says: The following item of evidence is, I think, valuable reference to the connection of certain diseases of the eye with gout. A gentleman, named W., consulted me on account of attacks of irritability, first of one eye, and then of the other. The eye would become a little red, and feel as if he had sand in it. The attacks would usually last from two to four days, but they recurred very frequently, and were a source of much annoyance. He had made his own diagnosis before coming to me, and remarked, "I never knew what they meant until, a year ago, I had an attack of gout in the great toe." He was of a dark complexion. He had of late, been very careful in his habits, but he inherited gout strongly on both sides. Having noticed the identity of names, I asked him if he was a relative of a certain Dr. W. "Yes," he said, "I am his first cousin, and there is the same inheritance in both of us." In the latter case the patient, then a young man, lost one eye from recurrent attacks of iritis, and had much damage to the other. His case is given in the series which I have published, illustrating the peculiar form of destructive iritis which goes with hereditary gout. Thus the two cases support each other, and afford strong evidence: firstly, as to the connection, with personal proclivity to gout of the "hot eye."—*Brit Med. Jour.*, May 29, 1886.

**LARGE BILIARY CALCULUS.**—At the recent meeting of the Paris Société de Thérapeutique, Dr. Bouloumié exhibited a biliary calculus weighing 20 grammes = 5.144 drachms. It was of cylindroid shape and measured 2 inches in length, 3½ inches in circumference, and on section 2 inches in the long axis of the exposed surface. The calculus consisted

almost entirely of cholesterine, with layers of biliary coloring matter, and a small quantity of salts of lime. The patient, a female aged fifty, had several attacks of hepatic colic, but made a good recovery.—*Lancet*, July 17, 1886.

### Medical Items.

Dr. Hunter McCluire, of Richmond, Va., is mentioned among the number of well-known physicians who are seeking rest during the summer months by travel in Europe.

Dr. Alfred S. Purdy, one of the oldest and most highly esteemed practitioners of New York City, died of pneumonia on the 23d of July, at his residence, No. 308 Madison Avenue.

At the recent meeting of the American Neurological Society Dr. John Van Bibber, of this city, was elected Vice-President for the ensuing year. Dr. L. C. Gray, of Brooklyn, N. Y., was elected President.

Honey is the most recent article recommended to disguise the taste of quinine. The dose should be placed in the centre of a teaspoonful. The credit for this suggestion is due to a writer in the *Lancet*.

The County Commissioners of Talbot County, Md., have organized a Local Board of Health, and have appointed Dr. J. H. M. Bateman, a widely-known physician of Easton, in that county, as the President of the Board.

The English hydrophobia commission is said to be retarded in its investigations by the difficulty of obtaining a rabid dog with which to test the efficacy of the protection afforded by inoculation.—*Boston Med. and Surg. Journ.*

It is stated by Dr. W. O. Roberts, of Louisville, Ky., now visiting London, in a letter to the *Amer. Pract. and News*, that Sir Henry Thompson does not do lithotripsy when the stone weighs over two ounces. In such cases he invariably does the supra-pubic operation. He has given up almost entirely the perineal operation. His chief reasons for preferring the supra-pubic to the perineal operation are the almost entire absence of hæmorrhage and the greater facility of removing the stone.

A correspondent writes to the *Boston Med. and Surg. Journ.* that he has lately witnessed the triumph of linseed oil in the treatment of pruritus and where all the classical remedies had failed. In the case of two patients who had been for several years sufferers from pruritus and with a trifling erythematous eruption and no rectal complications that could be discovered, the free external use of linseed oil at bed time about the parts gave immediate relief, and thus far free inunction with this simple remedy has given complete exemption from the nocturnal annoyance.

Dr. Haberkorn, in the *Centralblatt für Chirurgie*, No. 19, 1886, recommends very highly the administration of benzoate of sodium in erysipelas. He has used this drug in doses of from four to five drachms per diem, given in mucilaginous suspension or in seltzer water with marked success in this disease. In nearly every case in which the drug was so used the temperature fell to normal in 48 hours and a corresponding improvement was noted in other symptoms.

The King of Servia, according to the journals, has issued the following proclamation: "Whereas it is irrefutably proved by science that the so-called antiseptic treatment of wounds yields more beneficial results than all other methods, we are pleased to order that henceforward the said antiseptic plan of treatment be solely employed in all the hospitals of our kingdom, and that corrosive sublimate and iodoform be used until our further disposition."—*Med. News*.

The Board of Trustees of the University of Virginia have advertised for applicants for the Chair of Practice of Medicine and Obstetrics, made vacant in that school by the resignation of Prof. J. F. Harrison. It is generally understood that this is simply a custom required by law. It is generally believed that the Board will elect Dr. W. C. Dabney, of Charlottesville, to the position. Dr. Dabney is in every respect a most eligible candidate, and it is not probable, under existing circumstances, that he will have many to contest for the position with him.

"Steve" Brodie, the now noted character, who recently dropped from the Brooklyn Bridge, owes his life to the fact that he struck the water squarely, feet foremost, thus escaping shock. He is now reported to be the recipient of one hundred dollars a week from a Dime Museum. We recall the case of a sailor who fell from the top of a mast a distance of over 60 feet. He struck the deck fairly, feet foremost. The elasticity of the deck acting in the nature of a springing board cast him into the water. The only injury was a fractured tibia and fibula.

The Paris Academy of Medicine, after a discussion of three months concerning the relationship of micro-organisms to disease, has finally closed the debate, leaving the contest in pretty much the same position as when it began. The doctrines of leucomaines and microbes were very clearly stated, and the new theory of the microzymes was developed. According to this theory the microzymes are the undestroyed parts of the cell, which develop and assume new forms and new characteristics, according to the varying circumstances under which they may be placed. These microzymes are capable of development into microbes, which are virulent or innocuous according to the conditions under which they begin their independent existence. A committee has been appointed by the Academy to settle the question of the existence of the microzyme,



Original Articles.

OBSERVATIONS AND SUGGESTIONS IN REGARD TO THE METHOD OF OPERATING DURING THE SAME ANÆSTHETIZATION FOR LACERATIONS OF THE CERVIX UTERI AND RUPTURED PERINEUM.

BY THOS. A. ASHBY, M.D.,

Professor of Gynecology in the Baltimore Polyclinic and Post-Graduate Medical College, etc.

The two most important lesions of childbirth—laceration of the cervix uteri and rupture of the perineum—are frequently associated in the same individual. We may readily account for this coincidence in fact that the causative influences which tend to produce the one are also, in the majority of cases, at work to produce the other. Statisticians have vigorously compiled tables to show the great frequency of cervical lacerations, but no facts are available to show the relative frequency of perineal ruptures. The difficulties in the way of the collection of reliable data bearing upon this point are quite apparent. Unless we except ruptures through the sphincter ani, the lesions of the perineal body are about as difficult to classify in tables as are the spots on the moon. From a slight abrasion of the fourchette to the complete destruction of the perineal floor back to the anal sphincter an endless variety of lesions may be observed which have more or less significance according to their influence upon the subsequent health of the patient. Lacerations of the cervix uteri are more pronounced and are more apparent to the experienced observer. The slighter lesions of the cervix more readily unite by primary union than the slight perineal tears from the fact that the wounded surfaces are less exposed to the secretions and accidents which tend to defeat union by first intention. It is from the difficulties in the way of classification that figures are wanting to show the frequency of the perineal lesion, and the relative frequency with which these lesions occur at the same time in the same individual.

Without then calling to our aid statistics to show the common occurrence of the two lesions in the same individual, we assume this fact as a part of our experience and pass to the consideration of the treatment of the two lesions at one anæsthetization. In our early professional experience the two operations, when required in the same individual, were performed at different periods, the interval extending as long as six weeks or as many months. This method of practice was based upon the precedent of high authority and upon circumstances which were believed to exercise a more favorable influence upon the two operations as thus performed. Following the example of Sims, Emmet, and other recognized leaders, the silver wire suture was exclusively employed in our earlier experience and it is, in great measure, to this practice that we must refer our allegiance to the separation of the procedures by long intervals of time. The cervix operation was first performed, the patient being anæsthetized, and eight to ten days were allowed for union before the wire sutures were removed. During all this time the patient was kept in the recumbent posture. After the removal of the sutures a number of weeks were permitted to intervene before the perineal operation was approached. In the meantime hot-water douches, tonics, etc., were advised in order that the patient might be placed in the very best condition for the second procedure. A second anæsthesia and the details of a second operation were now gone through with for the closure of the perineum, and eight or nine days of subsequent nursing and, not infrequently, as many weeks of subsequent convalescence were the outcome of the second procedure..

The details and disadvantages of this method of operating are as real as they are apparent. The effects of two separate methods of procedure upon the patient were far from salutary, whilst to the operator the anxiety and labor were more than twofold. After an experience with the methods of separate procedures we were not regretful when an opportunity came to abandon them. This opportunity presented itself when the cat-

gut suture became one of the popular additions to our armamentarium.

Having tenaciously held on to the silver suture we were loath to abandon it for its now more popular rival, but the acceptance of the new for the old worked a complete change in the method of operating, and has so modified our views in regard to the treatment of these two lesions that we now occupy an entirely different relation to them. Latterly, we have invariably practiced the method of closing both lesions whilst the patient is under the influence of the anæsthetic, with results so simple and satisfactory that we seldom see just ground for separating the interval between the two operations.

The method of procedure is this: The patient is first prepared for operation by so many days or weeks of prior treatment as her condition demands. When she is in suitable health a day is set apart and the early morning selected, say the hour of 10 o'clock, for the operation. The patient is anæsthetized, and then placed in Sims' position. The edges of the torn cervix are properly pared and brought together with antiseptic cat-gut sutures. Beginning at the angle of the flaps the sutures are passed in parallel rows and as near to each other as they can be conveniently inserted. Three, four, five, or six sutures, or more, if required by the length of the flaps, are employed. The wound is now brought into close apposition and the sutures are tied, commencing with the one nearest the angle of the wound. After the flaps are in this way drawn together and adjusted a single wire suture is passed through each flap on both sides at the cervical opening. These are twisted to the required degree and the ends so cut off that the end-points cannot irritate or wound the vaginal tissues. This is best accomplished by converting the wire into a spiral and turning the end-points into the hollow of the spiral. The wire sutures are used as fixation sutures and on the theory that the strain upon the suture is greatest at the end of the cervical stump. It has never been found necessary to use more than one wire suture, on each side though in a case of an unusually

long flap or very thick cervix either silk or wire would be employed if necessary. The cat-gut suture has acted very satisfactorily in our experience. By the end of the eighth or tenth day it will most probably have disappeared by absorption, but in this there is an evident advantage. Primary union must result in from 48 to 72 hours, if it takes place at all, and the cat-gut suture, if of any value at all, will continue to hold the flaps in apposition until this time. We have found the cat-gut suture in position as late as the fourteenth day after the operation.

Having closed the cervix after the manner described, the patient is changed from Sims' to the recumbent posture, the perineal border is abraded of its mucous surface, and the tissues are brought together after the method of the perineal operation as advised by Dr. Emmet, or such modifications of it as may be indicated in the case. The perineum thus closed the patient is lifted into her bed and treated as after an ordinary operation for the closure of the perineal body. At the expiration of eight days the perineal sutures are all removed. The wound is bathed in antiseptic washes and the vagina is likewise syringed out with antiseptic injections. The patient is enjoined to remain quiet for the next five or six days, and usually by this time the perineal wound is so far well that the finger or speculum can be used to examine the cervix. Usually the sutures from the cervix are removed on the fourteenth or sixteenth day after the operation. Convalescence is rapid after this. During the operation every attention is given to cleanliness, and antiseptics—chiefly the bi-chloride of mercury 1 to 4,000—are carefully employed. Hæmorrhage has never proved to be a troublesome complication of the two procedures. The time required for both operations is from one hour to one hour and a half. This can be expedited by having an abundance of needles, sponges, and other instruments required for expeditious work. If the operator stops in the middle of an operation to talk, or to thread needles, or to sponge, he should not charge this delay to the operation. He should have



assistants and nurses to hand him instruments and to render necessary attentions, thus avoiding a very tedious and tiresome procedure. The results of these operations by the method here related have been just as satisfactory as by the old method in point of relief afforded the patients, whilst from the standpoint of comfort to patient and operator the gain has been immense.

By the conjoint method we gain, *first*, the closure of two lesions whilst the patient is under the anæsthetic. This is in itself a most important advantage to both patient and operator. We gain, *second*, a period of confinement to bed of about two weeks and a single convalescence, as compared with the weeks given to the operation at separate intervals and the anxiety and dread—born of experience—which were inseparable from this method. In the *third* place we save time and suffering by condensing two grave procedures into a single procedure which does not increase the danger in proportion to its apparent gravity. *Fourth*, the results of union are just as satisfactory by the new as by the old method.

### Hospital Reports.

#### CLINICAL NOTES FROM THE HOSPITAL OF THE GOOD SAMARITAN.

BY RANDOLPH WINSLOW, M.D.

Professor of Surgery in the Women's Medical College of Baltimore.

The hospital of the Good Samaritan was opened for the reception of patients in October, 1885. "It occupies, with the surrounding grounds, an entire square. The rooms and wards are large, well ventilated and lighted. Porches extend the entire width of the building on each floor, and meet the convenience of those who are unable to go abroad, whilst convalescents and many of the chronic cases can get all the benefit of the country air and surroundings amongst the trees and shrubbery of the spacious enclosure." The cheerful and homelike appearance of the hospital and grounds have commended it to the favor-

able notice of numerous physicians and have attracted a comparatively large and constantly increasing number of patients, so that probably more grave surgical operations have been performed within its walls during the past six months than in any other institution of its size in the city. Amongst these may be mentioned two laparotomies for the removal of the ovaries and fibroid tumors, one lithotomy, one operation for cure of exstrophy of the bladder, one of shortening of the round ligaments. (Alexander's operation).

The following cases, whilst presenting but few features that are rare, may at least be of sufficient interest to justify reporting them.

#### CASE.—I CARCINOMA MAMMÆ, AMPUTATION.

S. M., colored, married, has had three children, and says she is 46 years of age, but this is probably a mistake. Her menses are regular, and she complains of "womb disease." By occupation she is a washerwoman. Her mother is living and there is no family history of cancer or tumor. She first noticed a small lump by the side of the left nipple two years ago. This lump has steadily increased in size until at the time of admission almost the whole gland was involved in a hard, not much elevated, nodulated growth with sunken nipple, but without ulceration or discharge. Lancinating pains were present, the axillary glands enlarged and hard, the skin overlaying the tumor was adherent and dimpled, but the growth moved easily upon the pectoral fascia. The patient's health is good, she is well-nourished and has a splendid appetite.

From the hardness of the neoplasm the involvement of skin and axillary glands, the lancinating pains, and the comparative chronicity of the case, a diagnosis of scirrhus cancer was easily made; which as the microscope revealed, was slightly in error. We are reminded of the statement of S. W. Gross, in respect to the diagnosis of mammary tumors, that the only certain test is the microscope.

The day before the operation, the patient was made to take a general bath and just previous to operation, the breast and axilla were again thoroughly washed, and then irrigated with sublimate solution. The axillary hair was removed. Whiskey was given and chloroform administered. The whole breast was removed, the subjacent pectoral fascia dissected off and a piece of the pectoralis major muscle excised; the incision was then extended into the axilla, and masses of enlarged glands were enucleated with the fingers; some of these glands were placed deeply beneath the pectoralis minor muscle. During the dissection of the axilla a small opening was made into the axillary vein, which was collapsed and resembled a piece of fascia, this was secured with Pean's forceps, and subsequently tied laterally with catgut. This lateral suture was applied on the strength of an article by Dr. Pilcher, of Brooklyn, who showed that contrary to usual opinion an aseptic catgut ligature could be safely applied, without interfering with the function of the vessel. The sequel justified the method in this case. After the removal of the axillary contents the vein lay exposed for one and a half inches in the wound. The parts were irrigated with hot sublimate solution about 1-2000, iodoform then dusted on the wound, and a drain inserted through an artificial opening in the most dependent portion of the axilla. The axillary incision, and as much of the breast wound as possible, was closed with catgut, leaving a large denuded space in the center of the pectoral wound. Iodoform and gauze dressings were applied. For several days she suffered much pain in arm and axilla, which gradually ceased. Notwithstanding antiseptic precautions a slight traumatic fever developed, the temperature reaching  $102^{\circ}$  on the second evening, falling on the morning of the third day to  $99\frac{1}{2}$ , and the rest of the course was afebrile and the wound rapidly healed.

There are a few points to which attention is called. The occurrence of disease of the female genitalia is thought by Professor Willard Parker to have a causative relation to cancer of the

breast. It does not seem to me that this point is well taken, as a very large proportion of women at sometime of their history suffer from disease of the uterus and adnexa. This woman had some uterine disorders. The diagnosis made was scirrhus, but the microscope failed to reveal the usual typical arrangement of hard cancer, and showed a general carcinomatous infiltration. Clinically it was a very hard growth. When the great veins at the root of an extremity or in the neck are partially divided what is the best treatment? Many surgeons would ligate the vein in continuity, but having knowledge of the article by L. S. Pilcher in the *Annals of Anatomy and Surgery*, in which he shows the safety of applying a lateral ligature when an aseptic material is used, this method was employed with completely satisfactory results. In recent breast operations it has become my practice to perforate the posterior fold of the axilla, in order to allow drainage from the lowest point. The incision is then tightly sutured when possible, and usually healing by first intention is obtained.

Lastly, in my opinion ablation of the axillary glands should always be done in cases of breast tumor which are supposed to be cancerous, as in the great majority of cases diseased masses will be found, even though they cannot be felt from the outside. To remove a cancerous breast and leave a lot of diseased glands in the axilla is worse than useless. With sarcomatous tumors this rule does not hold equally good, as sarcoma does not often involve the glands.

#### CASE II.—ANNULAR STRICTURE OF RECTUM —LINEAR RECTOTOMY.

Mrs. W., colored, age about 40, nullipara, has had pain and difficulty in defecation for years; she is married, and denies ever having had any venereal disease, though there is a cicatricial closure of the upper portion of the vagina, which completely hides the cervix from view. Upon introducing the index finger into the rectum a stricture was detected, at a point two inches above the anus, which would only admit the end



of the finger. This stricture was annular in character, and was about half an inch in depth. The anus and rectum, including the stricture, were divided longitudinally down to the coccyx, with a bistoury. There was rather severe bleeding from the incision, but this was easily arrested by plugging the wound with iodoform gauze. The wound was washed out daily, and the patient did well, pain upon defecation ceased, and she rapidly improved in health and comfort, and when she left the hospital at the expiration of three weeks the incision had almost healed. Some weeks later this patient again came under notice, when the wound was found to be entirely united, and no trace of the stricture remained. How long this improved condition will last it is, of course, impossible to say, though it is claimed that better results are obtained by this method than by the use of bougies, or multiple incisions, or divulsion. I have done this operation several times and always with satisfactory results as far as the after history of the cases is known to me.

#### CASE III.—LYMPHOMA COLLI—ABLATION.

M. R., colored, female, age about 14, of a scrofulous habit, has a mass of suppurating and caseous lymphatic glands overlying the sterno-cleido-mastoid muscle at its upper portion, and extending underneath the muscle into the superior carotid triangle, causing a large swelling at the upper part of the neck. Not only was the girl's system endangered by such a growth, but her disgusting appearance prevented her from securing employment, hence it was determined to remove the diseased tissue by operation.

After careful washing and antiseptic irrigation, an incision was made into the suppurating mass over the sterno-mastoid, and a quantity of pus let out. A lot of broken down tissue was then removed with the sharp spoon, and the walls of the cavity thoroughly scraped until firm tissue was reached. An incision was then made behind the muscle and a lot of enlarged and caseous glands removed from beneath the cervical fascia,

making a deep cavity under the sterno-mastoid muscle, and in the anterior triangle of the neck. No large vessels were cut and the bleeding was slight. The wound was irrigated with hot sublimate solution 1-2000, and an iodoform dressing applied. The temperature and pulse ran rather high for three days, reaching, temperature  $103\frac{1}{2}^{\circ}$ ; pulse 138 on the evening of the second day, but falling to temperature  $99\frac{1}{2}^{\circ}$ , pulse 120 on the morning of the fourth day, and soon becoming normal. Efficient antiseptic precautions had been taken and I cannot account for the high traumatic fever. Mr. Arthur C. Baker, in the *Lancet*, January 30, 1886, also remarks upon the high temperature in the first twenty-four hours following extirpation of deep tumors from the neck, without other appearance of septic symptoms.

In regard to "scrofulous neck," as it is frequently called, a marked change of opinion has taken place in the last few years. It is now positively proven that the condition is a manifestation of tuberculosis, which, in many cases, is limited to the lymphatic glands, hence it becomes of the utmost importance to remove these infected glands before general infection occurs. It is not safe or judicious to trust the removal of these diseased glands to the processes of nature, or to depend upon the internal administration of drugs, but when the anatomical relations of the parts do not forbid surgical interference, they should be scraped out with sharp spoon or other curette, or enucleated or excised. These views, whilst well-known to surgeons, are not sufficiently recognized by the general practitioner, under whose observation cases of lymphomata usually come at an early period. *Chronically enlarged and suppurating glands ought to be removed without delay, in order to prevent the development of general tuberculosis.*

#### CASE IV.—OSTEITIS OF INFERIOR MAXILLA, ANCHYLOSIS OF JAW, WEDGE-SHAPED RESECTION.

J. M., colored, age 16, is a tall, healthy looking boy, with a marked

prominence of the right side of lower jaw extending from first molar tooth almost up the ramus to the condyle. This swelling began three years ago, with toothache, according to his own account, and there has been discharge of pus externally, the scars of the abscesses being still visible. The teeth appear to be sound. It has grown rapidly until the last six months, during which time he says it has remained stationary. The swelling was hard, evidently bony in character, not fluctuating or crepitating. He experiences very little pain, and the growth is not painful on pressure. The submaxillary lymphatic glands are very slightly enlarged. The mouth cannot be opened sufficiently to admit the introduction of the little finger, and it is on account of the difficulty of mastication that he seeks surgical aid. The difficulty in opening the mouth seemed to be due to the increased size of the bone which pressed backwards against the spinal column. His appetite was good..

An incision was made down to the bone in order to examine its exact condition, when the periosteum was found much thickened, and the bone vascular, spongy and in a state of inflammation. As no material benefit was likely to follow the excision of the ramus, a wedge-shaped piece was excised from near the angle in order to allow freer motions in mastication. The patient did well, his wounds soon closed, and he gained materially in his ability to chew his food. At the age of this patient a sarcoma, dentigerous cyst or abscess would be the most probable causes of an expansion of the bone, hence some little doubt was felt in regard to the diagnosis, though it was believed to be inflammatory in character, the correctness of which was proved by an incision.

### CLINICAL NOTES.

#### A CASE OF HYSTERIA.

Dr. F. P. Hoover, of Washington, D. C., requests the publication of the following :

The case which I relate, is one particularly interesting to me as I was ac-

quainted with the party personally and knew her to be an extremely interesting person, and one who did not give way to her feelings no matter what fatigue she had undergone or how indisposed she felt. Not being very strong, physically, yet she was one who was constantly on the go, so to speak. Her history is as follows :

Mary B., aged 20 years, was taken with chill, afterwards followed by fever, May 10th, 1886. I was sent for on the morning of the 12th. Upon my arrival I found patient in a profuse perspiration, nervous twitching of the lower limbs, hands and arms moving all the time over the bed clothes. Respiration short and quick; mouth partly open and eyes staring. Upon questioning she said she was *cold* not hot; her eyes were fixed upon her mother, not closing them the whole time I sat by her, which was fully fifteen minutes. Every now and then she would give a half inaudible sigh. I would state, the paroxysm of twitching of lower limbs never ceased from time I entered the room until I went into the communicating room to get a history from her mother, as I could not persuade the patient to talk after giving me the above information about herself. The mother said the patient was perfectly well up to May 9th, when she fainted in the afternoon from seeing her little brother's cut head, by falling off a wagon. She did not get over the shock that evening. The next day she moved about the house having little to say to anyone; could not eat anything, complaining of headache; said her leg's were weak; they were constantly giving way. She felt badly as if she had taken cold, first experiencing a cold sensation and then warm. The morning of 11th she did not come down to breakfast; upon sending a servant for her, she would not answer nor say how she felt. She then was shaking as if she had a chill. Supposing it was malaria her mother gave her a quinine pill, grs. v, (which she had in the house) four times a day, and kept her in bed. As she did not appear to be any better the next morning I was sent for. I found, upon examination, pulse accelerated, tempera-



ture 99°; her heart beat was perfectly normal. I had the mother keep a close watch upon her, and tell me upon my next visit if she had another chill, as she had none since the day before. I gave her potass. brom. grs. xv, ter die; also gave a dose of rochelle salts as her bowels were somewhat constipated. That afternoon about 5 o'clock I visited my patient again; meeting her mother in the lower hall, she told me she had gone to her daughter's door, which was ajar, quietly half dozen times since my first visit, and looked in; each time the patient was perfectly quiet and composed but the instant she went in and spoke to her the twitching commenced. She ate nothing and declined to take bromide, but took the salts in the morning. When I went up stairs I stood outside and looked in through the door; patient had eyes closed and seemed to be sleeping, but the instant she heard me walking she commenced the nervous twitching and sighing again. I was told by her mother, about one year before she had a nervous affection, which she thought had been entirely cured, as she had never had a return of the affection. I then concluded I had a case of hysteria and treated accordingly. The mother being anxious to leave town before June 1st, I told her to go to the country as the air and food would be of great benefit to patient, along with bromide and cod-liver oil and iron. The 22d of May they left the city; a week afterwards I received a letter from Mrs. B., informing me she was happy to say the long walks and rides had benefited her daughter wonderfully; she was getting more like herself every day. She never had a nervous attack, except when left alone and she had nothing to occupy her mind. I had a letter since saying they had left for the North, June 13th. Since writing me the first time she was glad to inform me her daughter had never had the slightest attack.

The Kentucky School of Medicine, located in Louisville, has had the misfortune to lose its entire premises and outfit by fire. The College has secured temporary quarters in which it will conduct its regular courses of instruction until can it rebuild.

## Abstracts and Extracts.

SOME ADDITIONAL STATISTICS OF INTUBATION OF THE LARYNX.—Dr. F. E. Waxham, of Chicago, read a paper on "Intubation of the Larynx as a Substitute for Tracheotomy in the Treatment of Diphtheritic Laryngitis, with a Report of 83 Cases," at a meeting of the Chicago Medical Society on June 21st. The author referred to the various modifications that had been made in the instruments during the past year. First, the enlargement of the tubes to prevent slipping into the trachea; second, the addition of a shoulder to prevent their expulsion; and third, the construction of the tubes with thinner walls, giving greater breathing space and a better opportunity for the expulsion of false membrane. After exhibiting a feeding-bottle and trachea-forceps, the author presented statistics of 306 cases of tracheotomy performed in Chicago, with 58 recoveries, or 18.95 per cent. In 138 cases the ages were given; the average being five years and one month. In contrast to these statistics he gave the result of 83 cases of intubation performed in Chicago, with 23 recoveries, or 27.71 per cent., the average age being three years and seven months. Eleven cases with 3 recoveries were under two years of age, one being an infant of fourteen months, another of eighteen months, and the other twenty months. Twenty-eight cases with 8 recoveries were under three years; 14 cases with 3 recoveries between three and four years; 15 cases with 6 recoveries between four and five years; 9 cases with 4 recoveries between five and six years; and 10 cases with 2 recoveries between seven and eleven years. Many of these cases were young nursing infants, and many were referred to him because they were too young, or because the cases were too unfavorable to warrant tracheotomy.—*Med. Record.*

A CURATIVE OF EPITHELIOMA.—Dr. D. Tod Gilliam, of Columbus, O., writes to the *Med. Record*: "I desire to call attention to the use of salicylic acid and cocaine as a curative for epithelioma. It so happened, not long since,

that I had a small epithelial growth to remove from the face, and resorted to a 20-grain solution of cocaine as a local anæsthetic. After the lapse of some minutes I was surprised to find the diseased parts not only exsanguined, as is usually the case after the use of cocaine, but extremely friable and crumbly. I saturated a good-sized pledget of absorbent cotton with the cocaine and re-applied it, leaving it on for about thirty minutes. At the expiration of that time the diseased mass fell away with the slightest touch of the curette, leaving a healthy-looking surface which has healed kindly. This, I dare say, was not an epithelioma in the sense of being malignant, but was undoubtedly epithelial in character, and has suggested to me the feasibility of using cocaine in the former class of cases. I was the more surprised at the change produced, inasmuch as the usual effect of cocaine is to produce a condensation of tissues, and the bloodless condition may, for aught I know, depend largely on this condensation. But the fact remains and we cannot gainsay facts. I would suggest as a preliminary to the use of cocaine that the horny layer of epithelium on the surface be softened by the application of salicylic acid, as we all know from experience that cocaine will not penetrate keratinic substance. In the absence of any case to demonstrate this treatment on, and as, unlike Bill Nye with the comet, I have not almost discovered one, I put this forward hoping that some one will give it a trial. I am not unmindful of the fact that Dr. Shradý and his *confrères* used cocaine in the case of General Grant, or that the drug has now for a long time been in daily use for similar cases, but possibly not of the strength, quantity, and for length of time here indicated."

THE TREATMENT OF THE ROUND GASTRIC ULCER WITH ALBUMINATE OF IRON.—How widely soever opinions may differ regarding the exact causation of gastric ulceration, all pathologists agree as to the relation existing between the affection and anæmia or chlorosis. The reason that the gastric ulcer, in spite of its unquestioned relation to anæmia, is

not treated by preparations of iron, refers, of course, to the digestive disturbance which this class of ulcers is pretty certain to create. Peters, Neuss, and other therapeutists, have even published especial papers to prove that iron is positively contraindicated in gastric ulcers.

It is therefore rather surprising to find in an article appearing in the *Berl. Klein. Woch.* of April 12, 1886, iron advocated as an effectual remedy for gastric ulcer. The published observations were made by Dr. Gempt with the *liquor ferri albuminati* prepared by Dr. Dreese, an apothecary of Bentheim (Hanover). This drug represents a salt in which the acid, as it were, had been substituted by albumen. It is of a neutral reaction, free from a metallic or astringent taste, well preservable, and highly absorbable.

Gempt had previously ascertained, in an experience of five years, that in chlorosis and anæmia the albuminate solution of iron was the most digestible and reliable of all preparations of iron; and, after having tried the remedy with success in the convalescence following upon gastric ulcer, he began to cautiously administer the drug also in cases in which the gastric ulcer was still present. The dose used by our author was one-half to one fl. drachm, given three times daily to adults and 5 to 30 drops for children, always to be taken before meal time. If a diluent be desirable, milk is the best vehicle. The absence of acidity in the drug precludes any injury to the teeth or mucous membranes of the digestive tract. Hence, Gempt observed in no instance, even after an uninterrupted use for several months, gastric pains or digestive troubles resulting from the remedy.

It should be especially mentioned that the drug appeared to exercise a direct influence upon the hæmorrhages from the stomach. The Carlsbad salt was found a useful adjuvant to the albuminate. In conclusion, Gempt makes the important statement that, aside of numerous other affections, this drug has repeatedly proved a cure in the incipient stages of pulmonary phthisis, the so-called catarrh of the apex.

If the albuminate of iron should in



reality be found to be wholly exempt from the objectionable features of other preparations of this metal, and at the same time to possess their medicinal value, the field of practical usefulness of iron would be widely increased.—*N. Y. Medical Times.*

**TOXICITY OF URINE.**—The Paris correspondent of the *Jour. of the American Medical Association* (July 31st, 1886,) writes: About a month ago, Dr. Bouchard, Professor of Pathology and General Therapeutics at the Paris Faculty of Medicine, read a paper at the Academy of Sciences in which he endeavored to show that the toxicity of the urine while a person was awake differed in quality and in intensity from that of a person during sleep. He then explained that these differences did not depend on the nature of the food nor upon the hours of meals, and that they are not in relation with the quantity of potash eliminated. For, wishing to complete his demonstration and to determine some other circumstances which, in a physiological state, increase or diminish the toxicity of the urine, Dr. Bouchard instituted a series of experiments permitting him to study the variations of the toxicity of the urine at the different hours of the day, without these differences being, in any way, imputable to the food taken. With this view, the day of twenty-four hours being divided into three periods of eight hours, he got the subject to take, at the commencement of each period, a repast always identically the same in the nature and in the weight of the food and of the drink. These experiments showed that the total amount of the urine during these three periods, viz.: sleep, the hours of being awake in the morning and those of the evening, which may be indicated, on an average, by the numbers 3, 7, 5. The augmentation of the production and of the elimination commences at the moment that the subject falls asleep, the diminution of the elimination commences in the middle of the period of wakefulness.

To ascertain the effects produced by abstinence on this toxicity, Dr. Bouchard went through another series of experi-

ments which formed the subject of another paper which he read at a subsequent meeting of the Academy of Sciences. The author states that he suppressed the repast at the commencement of one of the periods of sleep, and he compared the total toxicity of the urine secreted during that period with that secreted during the same period, and in which he allowed the regular ration. He arrived at a result which at first sight seemed paradoxical, inasmuch as the abstinence increased by half the toxicity of the urine. This fact was explained as follows: A person reduced to live at the expense of his own substance destroys with greater difficulty and more incompletely living matter; whereas in the conditions of normal ailment, he burns more easily and more completely the circulating material. The question is asked, what becomes of this toxicity under the influence of a day's corporal exercise of great activity, out in the country, and in the open air? Dr. Bouchard ascertained that it diminishes about one-third.

The author concluded his paper with the statement that in these physiological conditions, viz.: normal ailment, abstinence, sleep, wakefulness during rest, wakefulness during muscular activity, the variations of toxicity appear to depend particularly on the more or less greater intensity of oxidation.

In connection with the subject of the toxicity of the urine in physiological conditions, I may here make a note of a paper read by M. Felz on experiments performed by him to ascertain the toxic power of febrile urine. The experiments were performed with human urine of subjects suffering from typhoid fever, scarlet fever, acute tuberculosis, pneumonia, and acute articular rheumatism, which the experimenter injected into the venous blood of dogs. The results obtained were as follows: The so-called uræmic accidents, from the first efforts of elimination followed or not by effects indicating nervous, convulsive, toxic or clonic phenomena, leading always to coma and nearly always to death, are manifested much more rapidly than when normal urine is employed. These

phenomena are produced with urine in doses far inferior to those which would have been necessary if the experiments were performed with normal urine. The doses of intoxication are two-thirds or half inferior to the doses of intoxication of normal urine, and correspond to the volume of urine secreted by the dog in twenty-four hours at the minimum, or forty-eight hours maximum. The author adds that the toxic power of febrile urine is far from obeying the law of proportionality of densities. He found that there existed in pathological febrile urine agents of toxicity which are not found in normal urine, or which are represented in the latter only by quantities relatively very feeble.

PROF. DA COSTA ON THE TREATMENT OF ACUTE RHEUMATISM.—The Reporter of "Class-room Notes," in the *College and Clinical Record* (August, 1886), credits Prof. Da Costa with the following remarks: "We may begin with the assertion that no remedy has a specific action in this disease, but there are means which we may employ that will greatly lessen the after dangers. There are laid down two principal plans of treatment:—

1. Salicylic Acid and the Salicylates. These are unquestionably the most speedy remedies, but should not be employed in those cases in which much weakness exists, for it greatly increases the sweats and depression, or in those cases where tendency to cardiac complication is manifested. In these latter it has been stated to be worse than useless.

If the acid be used, which is preferable to its salts, give not less than sixty to ninety grains in twenty-four hours. Ten grains may be given in emulsion every hour, for six hours, if borne well, and then the same doses may be given at intervals of two hours.

If the salicylates are used, give three drachms in twenty-four hours. If this plan acts at all, it will do so promptly; and if good results are not achieved by the second or third day, it had better be abandoned.

2. The alkaline plan. This consists in rapid saturation with alkalies. It less-

sens the tendency to heart complication, but no good can be achieved by small doses; an ounce to an ounce and a half of either the bicarbonate or acetate of potassium must be given the first twenty-four hours, half as much the following day, and three or four drachms each day thereafter. Employ until the urine becomes neutral or alkaline, and then diminish the dose as above stated.

The bromides, which were formerly used, are not so rapid as the salicylates or so useful as the alkalies, but for lighter forms of the disease, with restlessness, they can be employed with good results. They also have some virtue against cardiac complications. In weak, exhausted cases, where the weakness occurs in repeated attacks, use the tincture of chloride of iron. This remedy is preëminently useful if the case be the least pyæmic, or of gonorrhœal origin. In treating this disease, no matter what plan be adopted, it is always of advantage to add to the other treatment ten or twelve grains of quinine per day. The treatment by blisters near the joint is effective, but very painful. If a case can be seen in which the joint remains involved, blister. It will always do good locally, and also have some good general influence.

As to local treatment, there is not much to say. We may wrap the joint in lint steeped in solution of potassii nitras, with a little tinctura opii added, and cover with oil silk. Some patients enjoy and get better relief from dry applications, enveloping the joint with cotton to which some powdered opium has been added.

*Complications.*—1. Carditis. Push the alkaline treatment to the utmost, supplementing by a certain amount of the bromides. We must give opium to relieve pain and procure rest and quiet. Digitalis is a valuable remedy, more so in endocarditis than in pericarditis. If seen early, use leeches locally. The Germans use ice over the heart, but this, to do any good, must be employed early. In most cases at the time when seen, relief can best be had by poultices, but a blister may do good.

2. For Cerebral Symptoms, if with



high temperature, besides the general rheumatic treatment, use quinine to reduce the temperature. More certain is antipyrin: give gr. vii—x every hour until impression is made, but it is not advisable to go beyond gr. xxx. We can also use application of cold cloths to abdomen, chest and limbs. Cerebral cases without high temperature do best on stimulus in large amounts, eight ounces in twenty-four hours."

PASTEUR AND SPITZKA.—Dr. E. C. Spitzka writes to the *N. Y. Medical Journal*: In view of the kind tone of your editorial remarks relating to my researches on pseudo-hydrophobia, I regret to be compelled to occupy some space in the journal with a correction. I have not attempted to provoke hydrophobia in dogs, but I have attempted to produce and I believe have succeeded in producing, in a series of six dogs, all the symptoms on the strength of which Dr. Liantard pronounced the dog biting Miss Morosini to be mad. Two of these dogs died with *spurious* dumb-rabies, if I dare coin such a term; one was killed, and three—of which two still show paralytic, and one among them mental disorder—are still alive. I concluded that Dr. Liantard had found a mare's nest, and needlessly alarmed the public by mistaking the ordinary symptoms of meningitis or cerebritis in the dog—symptoms that Mendel produced a year ago by placing dogs in rotation drums—for those of hydrophobia.

I have also expressed considerable skepticism about Pasteur's results. Dissected by logical critics in the manner Dulles, of Philadelphia, has followed, they appear inaccurately studied, hastily arrived at, based on insufficient premises, and involve actual fallacies. But I am not, nor have I ever been, in a position to deny that his allegations may contain a germ of truth. I simply ask for better proof than has yet offered, and, until it be furnished, may be permitted to occupy a position of reserve, and at the same time to protest against being assigned the position indicated in some recent newspaper headings—"Pasteur versus Spitzka" and "Spitzka versus

Pasteur." I have not done anything to merit being held up as a conspicuous antagonist of any one who, like Pasteur, has devoted more time to the subject than I have. My only purpose in discussing the latter in one of its aspects was to calm the public excitement which was unjustifiably and, I will assume, unintentionally fomented by one of the incorporators of a Pasteur institute. In this task the "*New York Tribune*" took a prominent part. A reporter of that paper, whose previous reports of an interview with me were unusually correct, recently approached me again and made some hasty notes, which I subsequently detected in company with extreme and exaggerated opinions in the *Evening Post*. I presume that the article in the latter paper misled you—a fact which I deplore, but which I was powerless to prevent."

LUNG RESECTION AND ABLATION OF A KIDNEY.—M. Demons read an interesting note at a recent meeting of the Paris Surgical Society. An adult was stabbed between the ninth and tenth ribs; there was a portion of the lung tissue that protruded and formed a mass about as large as an apple; the same day the patient passed blood with his urine, indicating a kidney wound. M. Demons resected by means of the "écraseur," the hernial portion of lung and applied the thermo-cautery to the surface. Some days after the operation there was purulent effusion on the left side of the thorax; chemical analysis of the fluid proved it to be principally urine. It was decided to remove the kidney; nephrectomy was performed in the lumbar region; the twelfth rib made the operation more difficult, but M. Demons, remembering M. C. Dentu's opinions, carefully avoided cutting it. The pedicle of the kidney was divided and carefully ligated; the wound was sutured with metallic threads; reunion took place by first intention; but two months subsequently a bundle of cellular tissue sloughed away and opened the cicatrice. It is now six months since the operation was performed and recovery appears to be perfectly established.—*N. O. Med. and Surg. Journ.*

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BALTIMORE, AUGUST 14, 1886.

**Editorial.**

THE "CICATRICAL PLUG OF EMMET."—Dr. T. A. Emmet, of New York, was not only the first observer to call attention to the influence of cervical lacerations upon the female economy and to propose operative measures for the relief of the same, but to him the profession is likewise indebted for the recognition of the fact that the cicatricial tissue often formed in the angles of the cervical lesion is as potent a cause of reflex disturbances of the nervous system as is observed in those cases where no attempt at a repair of the laceration has been made by nature.

Injuries to the cervix uteri during childbirth assume many different relations to the subsequent history of the individual who has sustained them, and may be viewed from a number of standpoints. Dr. Emmet doubts whether a woman can give birth to her first child without some laceration of the cervix uteri taking place. If this be a fact—we are not able to deny it—the cervical wounds are so many mouths remaining open after childbirth for the escape of blood, for septic absorption and for subsequent cicatrization. These lesions may have a subsequent influence upon the health of the individual out of all proportion to their gravity. Lacerations in the median line through the anterior and posterior lips of the cervix almost invariably heal by primary union. In the uni-lateral or bi-lateral tears extending

deep into the tissues of the cervix no such favorable union is likely to take place. The flaps are almost sure to separate and if closure results the union is by granulation and slow cicatrization. This process of repair is not infrequently accompanied by the formation of dense cicatricial tissue in the angles of the tear which by partially or completely filling up the gap draws the separated lips together. In every long-standing laceration of the cervix more or less of this fibrous tissue will be found. It is quite true its presence has been denied by some writers, but others, including such authorities as Emmet, Goodell, and Mundé, are just as positive of its existence and of its causative influence in the production of reflex disturbances. In point of fact the failure to recognize the existence and the influence of this cicatricial tissue has a ready explanation in the indisposition upon the part of some observers to investigate carefully for the lesion and an apparent unwillingness to assign to it a pathological influence. It cannot be denied that cervical lacerations frequently occur—remain open or close by cicatrization—without any apparent injury to the future health of the woman. Child-bearing may continue or sterility may be the result, the patient remaining in ignorance of a pathological condition of her generative organs. The significance of a uterine lesion is often determined by subjective symptoms rather than objective phenomena. There is an abundance of clinical evidence to show that reflex troubles are not dependent upon the extent or special character of the uterine lesion. This fact is fully illustrated in the clinical history of many women who have a "cicatricial plug" in the angles of an old lacerated cervix. The way in which this cicatricial tissue induces trouble, is thus explained by Mundé, "The dense cicatricial substance, by compressing the terminal nerve-filaments, gives rise to multitudinous and diverse reflex neuroses in other parts of the body." Dr. Emmet says, "after nature has repaired the injury by partially or completely filling the gap between the flaps by cicatricial tissue form-



ed in the process of healing by granulation, marked reflex disturbances will sometimes be established." There can be little doubt, we think, of the pathological influence of cicatricial tissue in a certain number of cases in which lacerations have occurred and due consideration should be given to its causative influence in provoking reflex troubles. We must ignore important clinical observation and teaching if we fail to regard the lesion in question.

This subject has recently been discussed in a very careful and thorough manner by Dr. W. E. Moseley, of this city. In a paper read before the Alumni Association of the Woman's Hospital, (*N. Y. Medical Journal*, July 24, 1886) entitled "The Influence, from a Clinical Standpoint of Cicatricial Tissue in the Angles of the Lacerated Cervix," Dr. Moseley undertakes to show, by way of exclusion, the influence that hard, or so-called cicatricial tissue, deep in the angles of the lacerated cervix, has in causing many nervous phenomena, such as headaches, general neuralgias, and general nervous irritability, which have been commonly included under the head of reflex nervous symptoms, and in causing, or at least perpetuating, the anæmia which almost invariably marks those cases of neglected laceration in which we are called to operate. To establish his position Dr. Moseley falls back upon clinical data. He furnishes clinical evidence in support of his views and convictions which will be difficult, if not impossible, to controvert. Dr. Moseley has been able to demonstrate that in certain cases, at least, certain morbid conditions of the nervous system resulted from the presence of this cicatricial tissue, and that relief followed its thorough eradication.

We commend Dr. Moseley's paper to those interested in this subject as containing most convincing proof of the correctness of Dr. Emmet's theory in regard to the baneful influence of this cicatricial tissue, now very properly recognized as the "cicatricial plug" of Emmet.

RECENT DEVELOPMENTS IN BRAIN SURGERY.—The boldness of the surgeon in

entering the various cavities of the body was recently illustrated in a most interesting manner in a case in which the most recent knowledge of the functions of the brain was successfully applied for the relief of an individual suffering from a brain tumor. The patient was admitted to the National Hospital for Epilepsy and Paralysis, London, suffering from so-called "Jacksonian" epilepsy of over two years' standing. The epileptic seizures began in the thumb, and Dr. Hughlings Jackson, arguing from some recent investigations on the cortical area for the upper limb, recommended the application of the trephine over the lower part of the area which is now believed to contain the special thumb center. Mr. Victor Horsley successfully performed the operation under antiseptic precautions. A tumor was found in the suspected spot and removed, together with the remainder of the thumb center. The wound healed and the patient has not had since a return of his epileptic fits.

### Miscellany.

CLIMACTERIC DIABETES IN WOMEN.—In an article with this title Lawson Tait says: Roughly speaking, the conclusions that I have arrived at concerning this affection are that in the great majority of cases of eczema of the vulva at the climacteric period, the disease is due to the presence of sugar in the urine. I have not yet come across a case of this kind in which, having examined for sugar, I have not found it. The disease seems to begin at or near the arrest of the menstrual functions, and to extend over a period of several years, then terminating in all probability by nature's own process. The sufferings of the patient are very much diminished, and probably the duration of the disease is shortened by the liberal administration of opium, whilst the local trouble is best mitigated by ointments containing such substances as will arrest the process of fermentative change in sugar. So far, the best substance that I have found for the purpose is the old-fashioned hepar sulphuris.—*The Practitioner*.

**PNEUMONIA.**—The idea of letting pneumonia take an undisturbed course because it generally shows the character of self-limitation, is absurd. It is an imperative duty no practitioner can escape to employ those drugs known to modify favorably the pulmonary lesion, and such complications as are observed to arise in its course. The absent chloride from the urine should suggest at once some abnormal state of the renal organs, and this should call forth such attention as the pathological state of those organs would indicate independently of the pulmonary disease.

It is an error to suppose the absent chlorides afford diagnostic evidence of pneumonia, or that the pulmonary lesion in such cases is the cause of the renal disturbance. The truth is the renal affection is separate and merely coincident with pneumonia. The same cause being able to affect different organs, as tuberculosis develops inflammation and fever, with colliquative sweats, so the *micrococci pneumoniae* generally disturb other organs as well as the lungs. The manner of introducing these determines the locality of the lesion. Most all the infectious diseases show severe local lesions at the point of inoculation, notably syphilis and tubercle.—*Progress.*

**TREATMENT OF A FORM OF DIARRHŒA IN CHILDREN.**—Dr. James Braithwaite in the *Brit. Med. Jour.* (July 17) writes:

There is a form of diarrhœa in children, usually occurring after weaning, and from that period to four or five years of age, which is characterized by the most horrible offensiveness of the motions. This is so marked, that it is generally at once mentioned by the parents. It is commonly met with in summer, but is not strictly what is known as infantile diarrhœa, in which disease the stools are sour, but not necessarily fœtid. Probably this form of diarrhœa differs from the diarrhœa of younger infants, in being caused by the growth of the ordinary bacteria of putrefaction. It is not amenable to treatment by any astringent, nor has any alteration of diet much effect upon it.

It may, however, be successfully treat-

ed by disinfecting the bowel contents by means of salicylate of iron, as in the following prescription, which is suitable for a child two years of age: Sulphate of iron ℞j; salicylate of soda ℞j; glycerine 3iij; water to three ounces. The iron and the salicylate should be dissolved separately, and the solution mixed. The color is darker than port wine, and the taste not unpleasant. One teaspoonful must be given every hour, until the stools become well blackened, which happens in about twenty-four hours; or a larger dose may be administered at longer intervals. The medicine should then be given every three or four hours, and occasionally a small dose of castor oil, to clear the bowels well out, and to get the secondary constipating effect of the oil.

I have employed this mode of treatment for many years. It was one result of a long series of microscopic observations upon the action of reagents upon the bacteria found in putrefying animal fluids, which I read before the Leeds and West Riding Medico-Chirurgical Society eleven years ago. The addition of the salicylate to the iron I made more recently.

In hospital practice, and amongst the poor, it is not so successful as it would be if it were possible to remove the child from the family living room, the air of which is usually very impure, and is made worse by the smells incidental to cooking, and the presence of a sink.

**DIEULAFOY ON BRIGHT'S DISEASE WITHOUT ALBUMINURIA.**—In a paper recently read before the Société Médicale des Hôpitaux (Paris), the author has described several cases of Bright's disease without albuminuria. The first patient was a woman, whose symptoms seemed to point to gastric ulcer. She had violent pain in the epigastrium and hæmatemesis; she also complained of constant headache, and was losing flesh gradually; the urine never contained any albumen; slight epileptiform attacks were followed by coma and death. At the post-mortem examination, the kidneys were found enlarged, and the microscope revealed the usual lesions of mixed ne-



phritis. In the second case, the most characteristic symptom was a paroxysmal dyspnoea, which could not be explained by any lesion of the heart or lungs; there was a frequent desire to micturate, and the patient also complained of headache; the urine was scanty, but contained no albumen, except on the day which preceded the death; the necropsy showed that there was a well-marked inflammation of the interstitial tissue of the kidneys. Several other cases of a similar description have been observed by Dieulafoy, who concludes that the urine sometimes remains quite free from albumen in Bright's disease; this is especially the case when the lesions are more advanced in the vessels than in the glandular substance of the kidneys.—*Med. and Surg. Reporter*.

**CATARACT IN GLASS-WORKERS.**—In the course of two years, Meyhöfer\* observed four cases of cataract in glass-workers under 30 years of age, healthy in all other respects. This led him to the examination of five hundred glass-workers, all of whom were engaged in glass-blowing or other work which kept them in the immediate neighborhood of the open furnaces. Fifty-nine presented cortical opacities of the lens, forty-two of these being under 40 years of age. The left eye was much the most frequently affected, this side of the face being the one generally more turned to the fire. In none of them could be discovered any disease of the fundus which could be regarded as cause, or as complication, of the cataract. The only general disease hitherto recognized as a cause of the early formation of cataract is diabetes. But this, according to testimony of physicians practising among glass-workers, is not specially prevalent among them, and in the eight cases whose urine Meyhöfer was able to examine he found no sugar. The author is of opinion that the cause of the cataract is the intense radiant heat from the open furnaces, and the consequent profuse sweating to which the men are subject-

ed. The left side being especially exposed to the direct heat, explains the greater prevalence of cataract in the left eye.—*Boston Med. and Surg. Jour.*

**DIFFERENT PREPARATIONS OF THALLIN IN ENTERIC FEVER.**—Mr. Mayrhofer, during the epidemic of enteric fever occurring in a Bavarian regiment, employed thallin in three different forms—namely, the sulphate, the tannate, and the tartrate; and obtained highly satisfactory results from them all. He gave the drug according to Ehrlich's continuous system, the doses being generally 0.2 gramme, repeated when the temperature rose. From 1.0 to 2.0 grammes were given per diem. The total quantity required varied from 8 grammes in mild cases to 26 grammes in severe cases with relapses. After taking the medicine, a profuse perspiration occurred, which invariably appeared to improve the patient's condition. No unpleasant effects were ever observed. There were altogether eighty-eight cases, of which three (that is 3.4 per cent.) died. It was not possible to say that one of the three preparations presented any marked differences in its action from the other two.—*Med. and Surg. Reporter*.

**IODOFORM IN PHTHISIS.**—The administration of iodoform in phthisis and other diseases of the lung is becoming the regular treatment of these affections. Two Italian professors have made it a special study, and the conclusions they have arrived at are very favorable to the employment of the agent. Professor Chiaramelli, during four years at the Hospital of the Incurables, tried iodoform on a large scale, and found that it lessened the fever, modified the expectoration in its chemical qualities, and thus hindered putrefaction. In cases of caseous pneumonia, this learned professor said he thought that, given at an early hour, it would have a happy influence on the disease. M. Verneuil, who has already used iodoform dissolved in ether, in injections for cold abscesses, has given it also in phthisis, in the dose of two grains twice a day, suspended in ether and enveloped in capsules. Dr.

\**Klinische Monatsbl. fuer Augenheilkunde*, February, 1886.

Huchard associates it with creosote (one grain of each).—*Med. Record.*

CRUDELI'S BACCILLI.—Lemon juice often proves a valuable adjunct in the treatment of intermittent fever. This fact is established in observing the action of the lemon juice on the growth of the bacilli in the culture tube. Citric acid acts more powerfully in the culture tube, and if sufficiently tried might prove equally so in the malarial fevers. All the science we have was established by experiment, and we should not avoid experimental methods in our therapeutics.—*Progress.*

TREATMENT OF PURULENT OPHTHALMIA.—In the treatment of all acute purulent inflammations of the conjunctiva it is important to note the fact that the element of contagion can not be destroyed by anything which would not destroy at the same time the conjunctiva and the cornea. The great point to be gained is to sterilize and keep sterilized the surface fluids so as to prevent the growth and development of the cocci.

It has long been known that gonorrhœal pus possesses an acid reaction on contact with litmus. This fact suggests at once the nature of the sterilizing agents. Carefully observed and faithfully recorded experience shows that solutions of borax, the carbonate and the chloride of sodium, each, when used singly, or in various states of combination, prove efficient in the treatment of gonorrhœal ophthalmia, when used persistently from the first, and at short intervals.—*Progress.*

RADICAL CURE OF HERNIA BY A BUBO.—Dr. F. B. Streeter, of Glen Falls, N. Y., reports the following case in the *Med. Record*: "H—, aged thirty-five years, Irish-American, canal-boat captain by occupation, while loading his boat in the summer of 1882 sustained a severe strain which resulted in a direct inguinal hernia of the left side. It was easily reduced and retained by a truss. In the summer of 1883 he again consulted me, this time for a bubo on the same side.

After a long period of extensive inflammation with suppuration, during which he was unable to wear a truss, he recovered from his bubo, and from his hernia as well. Up to the present time his hernia has not recurred, although he is engaged in the heaviest labor. A suitable case presenting itself, I propose to try the effect of vaccination, although I hardly expect to gain results equal to those obtained by the 'bubo' treatment."

HYSTERICAL FEVER.—M. Barrié has met with, at the Bicêtre Hospital, a case of hysterical fever, which he described at a recent meeting of the Paris Biological Society. The patient was the wife of one of the hospital servants. One morning, when recovering from an attack of hysteria, she was seized with hemiplegia on the left side. She was admitted into one of the wards to be treated, and had as many as thirty hysterical attacks; hemiplegia continued, although every curative means was adopted. It disappeared suddenly, after an unusually violent hysterical attack. The skin was dry and feverish, the thermometer placed in the armpit marked 39° cent. (102 Fahr.). The next morning 38.6° (100.6 Fahr.). The following days the temperature was carefully taken by placing a thermometer in the armpit and another in the rectum. Shamming was impossible, the temperature registered was correct. The hysterical attacks at this juncture were constant, sometimes subintrant; the patient was rarely able to take food. One day the temperature rose to 40° cent. (104 Fahr.) in the morning and fell some tenths of a degree. Notwithstanding that the fever continued three weeks there was no disturbance of the principal organs; the tongue was moist and quite normal. After twenty days of fever, defervescence occurred suddenly, and the attacks of convulsions disappeared subsequently.—*N. O. Med. and Surg. Journ.*

NEURALGIA OF THE PUBIC NERVE.—Professor Adankiewicz mentions in the Polish journal *Medycyna* a somewhat rare case of neuralgia affecting the pudic nerve. The neuralgias of the ovary and



uterus in women and of the seminal ducts in men are, he says, usually described as neuralgiæ pudendo-hæmorrhoidales, but they have not been well worked out. The present case is interesting because the nerve affected arises from the pelvic plexus. Three years ago the patient began to suffer two months after her second confinement with painful spasm of the urethra whenever she attempted to micturate; sometimes, indeed, this spasm prevented her from voiding her urine. Afterwards the pain spread to the vesical region and became more and more frequent, so that at last the woman was scarcely ever free from it. Every movement of the body and any irritation or excitement increased it, and induced a desire to micturate. Morphia and absolute rest in bed produced some alleviation only. A painful spot was found where the gluteus maximus crosses the tuberosity of the ischium, and another on the inner surface of the ascending ramus of the ischium. The treatment adopted was electrical, the anode of a constant current battery being placed between the tuberosity and the spine of the ischium, and the cathode on the sacrum. After daily applications of a few minutes' duration for three months the patient was completely cured.—*Lancet*, July 24, 1886.

THE FUNCTION OF THE TONSILS.—Dr. R. Hingston Fox, in an interesting article on the Functions of the Tonsils in the twentieth volume of the *Journal of Anatomy and Physiology*, expresses the opinion that these glands belong to the digestive and not the respiratory tract, and that their function is to reabsorb certain constituents of the saliva in the intervals of meals which would otherwise be wasted. He thinks that the view of their having an absorbing function is further supported by the strong evidence of the power of the tonsil to absorb morbid poisons directly from the saliva.—*Lancet*.

ESERINE AND PILOCARPINE FOR GLAUCOMA.—It has been objected against eserine that it increases the intra-ocular pressure whilst contracting the pupil;

pilocarpine, on the other hand, is said to lower the intra-ocular tension. These myotics have been set against one another in the treatment of some cases of glaucoma. Schlegel has made some experiments on the intra-ocular tension, and arrives at the conclusion that the alkaloid of jaborandi also increases the tension.—*Lancet*.

ARBUTIN.—Dr. Borisoff, of St. Petersburg, having recently examined "the pharmacological action of arbutin, a glucoside obtained from the leave of *Uva ursi*," by means of experiments on dogs and frogs, finds that it has a decided diuretic effect, due to stimulation of epithelium of the Malpighian bodies and urinary tubules of the kidneys. Though large doses of arbutin exercise a paralyzing effect on the brain of the frog, little general disturbance is caused by the drug in warm-blooded animals, even if given in considerable doses. It exercises a distinct antiseptic influence in lessening the formation of pus in cases of purulent inflammation of the bladder and kidney. Dr. Borisoff thinks this drug may be found of much use in practice. He would give larger doses than those which have been suggested by some writers—e.g., M. Levine. He would commence with from one to two grammes (fifteen to thirty grains), given several times a day in powder or dissolved in water. He has made a diligent search through the scientific journals of all nations for the literature of the subject, and has collected no less than forty-three different articles, mostly from German sources, but with a few American and Russian exceptions.—*Lancet*.

EARLY OPERATIVE TREATMENT OF MORBUS COXÆ.—The April *Bulletin* of the Royal Academy of Medicine of Rome reports the presentation, by Dr. P. Postemski, of three boys with hip-disease. Two cases had been treated by the expectant method—counter-irritation and extension, douching and immobility. Abscesses and sinuses formed, and recovery, with considerable deformity, only occurred after the treatment had been persist-

ed in—in one case for two, in the other for four years. In the third case early excision of the head of the femur was followed by rapid recovery. The operation was performed through a semi-lunar incision behind the great trochanter. The joint contained purulent serum, and was the synovitis. Only a few erosions were visible on the head of the bone. After removing it, the neck of the femur was rounded and refitted into the acetabulum, previously cleaned out by scraping. Drainage, union by interrupted suture, extension, and sublimate dressings were not disturbed for twenty-nine days, when union by first intention was ascertained. All the dressings were removed on the thirty-fifth day. At the end of eight weeks the patient was able to walk on crutches, and he could dispense with them when presented to the Academy. The case is unquestionably one of deep interest, but the progress at a latter stage must be noted before a correct judgment can be formed. Assuming the issue to be entirely favorable the advice to excise the head of the bone in the early stage of hip-disease raises grave questions. Granted that the danger of the operation is much less in children than in adults, and that the proportion of recoveries is largest when excision is practiced before the joint is completely disorganised, two results of experience are specially noteworthy. A large proportion of hip-joint patients do well under appropriate constitutional and local treatment; and excision of the hip is an operation involving risk to life, without the certainty of a strong and useful limb.—*Lancet*, July 24.

**GALVANIC FLANNEL**—A novel method of applying an electric current to the body forms the subject of a patent granted to the agent of Senor Pulmariaga, of Avile, Spain (2,322, 1886). The inventor steeps flannel in a bath composed of equal parts of oxide of iron, copper, zinc, and tin, mixed in fine powder in weak gum-water. The flannel thus takes up a quantity of the metallic oxides which are excited by the perspiration of the body, which is then subjected to a weak but constant electric current.—*Med. and Surg. Reporter*.

**CHARCOAL AND CAMPHOR IN CHRONIC ULCER**.—A mixture of equal parts of camphor and animal charcoal is recommended by Barbocci as an application to prevent the offensive odor and remove the pain of old excavated ulcers. The camphor acts as a disinfectant, and the charcoal absorbs and destroys the offensive odors.—*British Med. Jour.*

**SURE SIGN OF DEATH**.—When a great ruler dies in Europe some one calls in his ear three times. Once is enough in Kentucky. A friend steps reverently to the couch of the deceased and whispers—not necessarily loud—"Let's take a drink." If he makes no reply, then he is dead beyond peradventure, and the funeral is proceeded with.—*Archives of Pediatrics*.

**HYPERIDROSIS**—For sweating of the hands a saturated solution of tartaric acid should be tried, letting it dry on the hands. Use this four or five times a day. The acid may be used dry in powder if preferred.—*Canadian Prac.*

**CHRONIC ECZEMA OF GENITALS AND ANUS**.—Vidal uses the following formula :

℞ Ol. cadini, 5 parts ;  
Glycerit. amyli, 30 parts. M.  
gradually increasing the strength until it contains fifty per cent. of oil of cade. Lotions of solutions of chloral hydrate (two and a half to five per cent.) or chloroform (one per cent.) will relieve itching.—*Med. Times*.

**HYPODERMIC INJECTION OF CARBOLIC ACID IN ERYSIPELAS**.—In the venereal wards, under the care of Dr. Montes de Oca, in Buenos Ayres, considerable success has been obtained in cases of erysipelas by the injection of a 3 per cent. solution of carbolic acid, as recommended by Hueter, Boeckel, and Sukowenkoff. Care was taken to introduce the carbolic acid as near as possible to the part attacked. In one case where a patient with syphilitic cachexia had been attacked for the second time, six injections, two being given daily, served to limit the affection to the right ear, which was the part affected, and to entirely prevent its spreading further.—*Lancet*.



CATHETERISM OF THE URETER.—Dr. Léo Warnots, surgeon to the Hospital of Saint Jean, has been awarded the degree of Doctor of Medicine with *la plus grande distinction* by the University of Brussels, for his thesis on "Catheterism of the Ureters in the Female." The author discussed the methods of G. Simon and of Pawlik, collecting a large number of facts in support of his views, and thus contributing to show that this operation may in some cases be of great value where operative interference with the kidneys of a female patient are contemplated.—*Lancet*, July 17, 1886.

# THE INQUISITION AND CREMATION.

AN EPIGRAM.

(For the Maryland Medical Journal.)

The Dead are ours, the Fathers say,  
To poison, stink and rot away;  
The living only must we roast  
For Father, Son and Holy Ghost.

JOHN HUSS.

ERRATA.—In consequence of an accident in proof-reading upon the part of our printer, by which the matter went to press without correction, we wish to direct attention to the following typographical errata occurring in "A Historical Sketch of the Disease Actinomyces" appearing as an editorial article in this JOURNAL for August 7th, 1886.

On page 294, 1st column, 24th line which should follow to that; in 29th line *Beobachtungen* should read *Beobachtungen*; in 36th line &c. should follow "wooden tongue;" in 2nd column, 23rd line, should follow *in man*. On page 295, 1st column, 1st line *Veterinärecessen* should read *Veterinärvesen*; in 19th line "askakakkus" should read "askokokkus;" in 21st line *Rivalta* should read *Rivolta*; in 22nd line *discometiti* should read *disconiciti*; in 28th, should follow *Ponfick*. On page 295, 2nd column, 5th line where should read *whose*; in 7th line 33 should read 38; in 18th line *point* should read *points*; in 38th line, should follow *pleura*. On page 296, 1st column, 3rd line, should follow *discoloration*; in 4th line *ponds* should read *points*; in 7th line, should follow *white*; in 16th line the should follow *with*; in 17th line, should follow *eye*; in 29th line *gummy* should read *gumma*; in 31st line *as* should follow *tract*; in 38th line *for* should read *from*; 39th line, should follow *form*. On page 296, 2nd column, 19th line *moula* should read *mould*; in 26th line *acteno-mycēs* should read *actino-mycēs*; in 35th line *Bastram* should read *Boström*; in 42nd line *pointed* should read *jointed*; in 47th line *tissue* should read *tissues*; in 53rd line, should follow *mould* and *supposed*; in 55th line *clodothrix* should read *cladotrix*.

## Medical Items.

Dr. J. T. Whittaker, of Cincinnati, has expressed as his opinion the conclusion that intubation of the larynx can never take the place of tracheotomy, either in croup or diphtheria.

Prof. Bartholow, in *incontinence of urine*, occurring in a girl 12 years of age, directed the following:—

R.	Ext. ergotæ,	gr. j	
	Ext. nucis vom.,	gr. ½	
	Ext. belladonnæ,	gr. ½	M. •

Ft. pil.

Sig.—Take three times a day.

Also—

R. Pil. ferri iodid.

Sig.—One ter die.—*Col. and Clin. Record*.

FANCY-BRED RABIES.—An English writer, Crawford, is authority for the statement that an American named Stephens, to test his theory that hydrophobia is fancy-bred in man, never loses a chance of getting bitten by a mad dog. He has been wounded by canine teeth forty-seven times. As there is certainly such a disease as simulated rabies, he advises some society for the diffusion of useful knowledge to scatter broadcast the small volume on "Le préjugé de la Rage," by Fangère Dubourg, and what was written on this subject by such lights of science as Bouley, Brechet, Tardieu, Majendie, Boudin, Vernois, Sausen, Renault, Donnat, Baron Portal, and Dupuy.—*Medical News*.

*Progress* calls this a sort of campaign year in the medical history of the country, all on account of the approaching meeting of the International Medical Congress. Our contemporary advances the idea that the West is about to secede from the East and in future will conduct her medical work under her own vine and fig tree. The able investigators in every field of medicine and surgery in the West, whose labors have been known heretofore chiefly through the societies and journals of the East, are invited to withdraw from this unholy alliance and flock to the standard of the Western organizations and journals.

The programme of the annual meeting of the American Dermatological Association has been received. The meeting will be held at the Indian Harbor Hotel, Greenwich, Ct., on August 25, 26, and 27, 1886, under the Presidency of Dr. Edward Wigglesworth, of Boston. Among the papers announced, are two by Dr. I. E. Atkinson, of this city, one on "Rötheln" to be read at the morning session August 25, and the other on "Surgical and Obstetrical Scarlatina" at the evening session, August 26th.

We are requested by the Librarian to announce that the Library of the Medical and Chirurgical Faculty of Maryland will be closed from August 16 to August 31st inclusive.

CIRCULAR No. 2, concerning the Ninth International Medical Congress, to be held at Washington, has been issued. The Congress will assemble at Washington, Monday September 5, 1887, at 12 o'clock, noon, and will consist of such members of the "Regular Medical Profession" as shall have registered and taken out their ticket of admission, and of such other scientific men as the Executive Committee of the Congress shall deem it desirable to admit. A list of the officers of the Congress is given.

During the present week the British Medical Association is holding its Fifty-fourth Annual Meeting at Brighton. It is greatly to be desired that our English brethren will enliven the present monotony of the season by the presentation of something new either to literature or science. Since the Congress controversy ceased and the cocaine "craze" exhausted itself the pages of our exchanges have assumed the withered aspect of the autumn foliage. Not even Pasteur's exploits nor the cholera epidemic have been able to enliven or freshen the countenances of some of our most welcome visitors. Verily this is a dry year for the journalist!

The Mississippi Valley Medical Association has set in motion the work of organizing a general Association of the profession in all the States and Territories west of the Alleghany Mountains. This organization is designed as a sort of rival association to The Association of American Physicians recently organized in the East. It seems that some of our professional brethren in the West are tired of paying tribute to the East and propose in this manner to run an Association to meet their own scientific aspirations. In the meantime what is to become of the American Medical Association so recently adopted by the profession in the West? Is the "old mother" to be ground under the heel of her offspring?

As foreshadowed in our last issue Dr. Wm. C. Dabney, of Charlottesville, Va., has been elected to the Chair of Practice of Medicine, Obstetrics and Medical Jurisprudence, in the Medical Department of the University of Virginia. With Professors Dabney and Towles as recent additions to the departments of medical instruction assigned to them, the University enjoys an accession of fresh blood which must materially add to her health and vigor. As a school of technical instruction in medicine the University has deservedly enjoyed a high reputation. We have no doubt this standard will be fully maintained under its present Faculty. We incline to the belief, however, that the day is passing away for a purely theoretical system of education in medicine. The advantages for laboratory and clinical instruction now offered by the leading medical schools of our large cities are necessary outgrowths of the demands of the times which press to the background the older and more obsolete methods of imparting knowledge. The age is eminently practical and practical instruction is now in demand.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, from August 3, 1886, to August 9, 1886.

Retired—Brigadier General Robert Murray, Surgeon General, U. S. A.

Major Wm. D. Wolveston, surgeon, granted one month's leave of absence, to commence on or about August 15, 1886.

Major Edwin Bentley, ordered from Dept. Texas to Dept. East.

Capt. D. M. Appel, asst. surgeon, ordered from Dept. East to Dept. Texas.

Major Passmore Middleton, surgeon, granted leave of absence until Sept. 10, 1886.

Capt. R. H. White, asst. surgeon, ordered from Angel Island, Cal., to San Diego Bks., Cal., relieving Capt. Leonard Y. Loring, asst. surgeon.

Capt. Leonard Y. Loring, asst. surgeon, granted leave of absence for one month, on surgeon's certificate of disability, with permission to apply for an extension of two months.

Capt. Geo. W. Adair, asst. surgeon, ordered for duty as post surgeon, Ft. Brady, Mich.

1st. Lt. Chas. M. Gandy, asst. surgeon, granted leave of absence for one month, with permission to apply for one month's extension.

Capt. James C. Merrill, asst. surgeon, assigned to duty as post surgeon at Ft. Klamath, Oregon.

Capt. Robert B. Benham, asst. surgeon, retired from temporary duty at Ft. Omaha, Neb., and ordered to Ft. Bridger, Wy.

#### APPOINTMENTS.

To be Assistant Surgeon with the rank of 1st. Lieutenant:

Henry S. T. Harris, January 5, 1886.

Leonard Wood, January 5, 1886.

William B. Banister, January 26, 1886.

Charles F. Mason, May 5, 1886.

#### PROMOTION.

To be Surgeon with the rank of Major.

Capt. John H. Barthorp, asst. surgeon, Jan. 4, 1886.

Capt. James P. Kimball, asst. surgeon, Jan. 24, 1886.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, for the week ended August 7, 1886.

Hutton, W. H. H., surgeon. To proceed to Key West, Florida, for temporary duty, Aug. 7, 1886.

Bevan, A. D., asst. surgeon. Ordered to examination for promotion, Aug., 1886.

Williams, L. L., asst. surgeon. When relieved at Buffalo, New York, to proceed to Mobile, Alabama, for temporary duty, Aug. 2, 1886.



## Lectures.

### DISEASES OF THE LACRYMAL APPARATUS.\*

*A Lecture Delivered at the Royal College of Surgeons.*

BY HENRY POWER, F.R.C.S.

GENTLEMEN,—The diseases of the lacrymal organs have attracted the attention of surgeons and physicians from the most remote periods, for it was impossible that the inflammations and tumors of these parts, with their attendant symptoms of pain and redness, closure of the lids, temporary loss of vision and oftentimes severe constitutional symptoms, could be overlooked; and we accordingly find that the oldest practitioners with whose writings we are acquainted—Galen, Celsus—nay, even Hippocrates himself—described the symptoms, devised means of relief for the acute kind, and suggested various proceedings to prevent their recurrence.

The lacrymal apparatus is of a very complicated nature; the causes leading to disease in it are very diverse; the conditions presented vary greatly in different cases, and require for their treatment a corresponding knowledge and intelligence on the part of the surgeon. It is not surprising, then, that the treatment adopted, from limited experience in one class of cases by one surgeon, should be found inadequate and inefficient by others in a different class; and hence has arisen a wealth of remedial means, and such an armamentarium of instruments as is scarcely to be equalled in any other department of surgery—a sure sign of uncertainty in their application and disappointment in their effects.

An additional reason for the unsatisfactory nature of our treatment of lacrymal disease is to be found in the circumstance that we possess very little information in regard to the morbid conditions which accompany or cause the diseases that are so familiar to us. I think I am correct in saying that neither

in this museum nor in any other belonging to the great schools of the metropolis, with the exception of St. Bartholomew's, is there a single preparation showing the normal or diseased condition of the lacrymal apparatus. Lacrymal gland, sac, and duct has not been investigated, because such an examination would involve very considerable disfigurement of the face. Nothing, in fact, can show more clearly the great importance, in the scientific development of medicine and surgery, of a thorough knowledge of pathology. If we possessed such knowledge in the case of lacrymal disease, our treatment, which is now purely empirical, would at least become rational, and the various plans of treatment which have been found occasionally to prove successful, and very frequently to fail, would be applied in those cases only for which they were especially adapted.

A few facts in regard to the statistics of lacrymal disease may be mentioned. Taking three years, and using the numerous tables of various ophthalmic institutions and practitioners in Michel's *Jahresbericht*, it appears that the proportion of lacrymal diseases of all forms to other diseases of the eye in a total of 500,000 is about 3 per cent. This may be taken as well assured, though special observers vary in their statements from 2 per cent.\* to 6 per cent.† The records of the books of St. Bartholomew's Hospital show that during the ten years from January 1st, 1874, to December 31st, 1883, the total number of in-patients was—males 1685, females 1430. The number of cases of lacrymal disease amongst the males was 27, or 1.6 per cent. The number of cases of lacrymal disease amongst the females was 61, or 4.26 per cent. Taking both sexes together, the proportion is 2.8 per cent. The records of the out-patient book shows that during the same period there were in attendance 2337 males and 1934 females. Disease of the lacrymal apparatus was noted in 71 males and in 119 females, or 3.16 per cent. of the males

\*Hasner. Beiträge zur Anat. und Phys. des Thränenableitungsapparats. Prague, 1850, p. 66.

†Wecker, 1st edition.

\*From *London Lancet*, July 31, 1886.

and 6 per cent. of the females, or together 4.58; but some of these were probably discharged in-patients who were directed, on leaving the hospital, to return in order that the treatment might be continued. The diseases of the lacrymal gland appeared to be more prevalent in some years than in others. Thus, whilst there were 8 cases in 1874, 12 in 1875, 11 in 1876, and 11 in 1877, in 1878 the number rose to 38, and in 1879 there were 32 cases; in 1880 the number fell again to 11, in 1881 it was 17, in 1882 it rose to 33, and in 1883 it was 17.

It is acknowledged by all who have compared the numbers that women are much more subject to lacrymal disease than men, the proportion being about two or even three to one. Thus, Nieden found in his practice 62.1 per cent. of females and 37.9 of males; v. Hasner, 74.5 per cent. of females and 25.5 of males; Schirmer, 67.0 percent. of females and 33.0 of males. The cause of this disposition on the part of women is not easy to explain. Men are certainly more exposed to variations of weather; but then their activity is greater, and we may refer the difference with some probability to the sedentary occupations of women, to their greater proclivity to tears, and perhaps to the smaller calibre of all the ducts.

Nieden has advanced evidence to show that there is a hereditary tendency to lacrymal disease in all its forms—epiphora, stricture, and dacryocysto-blenorrhœa. In 9 per cent. of all lacrymal affections parents and children were affected, and the proportion in which the hereditary transmission occurred from mother to child was 63.3 per cent., whilst from father to child it was only 36.7 per cent. There was thus shown to be a special predisposition in children whose mothers had been affected. All authors agree that the lacrymal organs of the left side are more liable than those of the right. The following table shows the proportion in percentages:

	v. Hasner.		Schirmer.		Mooren.		Nieden.	
Both eyes	11.8	....	29.3	....	13.7	....	58.0	
Right eye	32.2	82.2	25.6				26.2	42.0
Left eye	56.0		45.1	70.7	86.2		15.8	

The nomenclature of the different affections of the lacrymal apparatus varies so much that it is difficult to draw any conclusions as to their relative frequency. For example, in the very complete statistics issued by the Presbyterian Eye, Ear, and Throat Charity in the States, there were 148 cases of abscess of the sac in 939 cases of lacrymal disease occurring amongst 22,335 general patients. Mooren, on the other hand, amongst 32,425 ophthalmic patients, only met with one case of dacryo-cystitis, which, if not a typographical error, is remarkable.

Having made these preliminary observations, I think that this lecture may be profitably devoted to the diseases of the lacrymal gland. I do not propose to enter into minute detail in regard to its structure, because when I had the honor of being the Arris and Gale Lecturer in this place I gave as fully as I was able the results of modern histological research. Nevertheless, it may be worth while to recapitulate the chief points of interest in regard to the anatomy and physiology of the gland and its secretion. In the first place, then, the lacrymal gland is divisible into two parts: a larger solid bean-shaped body occupying the hollow in the outer part of the orbital plate of the frontal bone; and a smaller, thinner, or flattened portion, separated from the former by a fibrous septum, and lying in front and beneath it. The former is the ganglion innominata of Galen, the latter the accessory gland of Rosenmüller, and they are sometimes named the orbital and palpebral portions of the gland. The orbital plate of bone is curiously cancellous in some skulls at the part where it has been in immediate relation with the gland, as is well shown in this negro's skull. [No. 1225, Negro, Hunterian Museum.]

The histological characters of the orbital portion of the lacrymal gland are those of an albuminous gland. In the fresh state the cells are so crowded with granules that their limits are not so easily defined, though they may be rendered distinct by the addition of dilute acetic or chromic acid. They possess an oval nucleus. The cell protoplasm is



finely fibrillated. When stimulated (Reiched\*) the cells, like those of the albuminous glands generally, become smaller and more granular. Heidenhain† remarks that the excretory ducts of the lacrymal gland differ from those of other albuminous glands in the absence of the usual rod-like character of the cells. In many parts there are blind tubes lined with columnar epithelium. The glands are fairly supplied with bloodvessels, the chief artery being a special branch of the ophthalmic. The nerves supplying the gland are derived from the fifth and sympathetic, as well as perhaps from the subcutaneous malæ; and Boll describes both medullated and plain nerve fibres running to the alveoli, whilst numerous branched cells are found between the alveoli, the communication of the process of which form a kind of plexus. Under ordinary circumstances the orbital portion of the glands acts only very slightly or not at all. On the other hand, there is pathological evidence to show that the palpebral portion always secretes and aids in maintaining the brightness and polish of the cornea. The secretion of tears can be called forth by exposure of the nerves in the orbit and stimulation by electricity or other means. Usually, however, it results from reflex stimulation, either through the sensory branches of the fifth distributed to the conjunctiva or nose, or through the optic nerve, on exposure of the eye to a bright light, by strong irritation of almost any sensory nerve, by mental emotion, and by any condition causing flushing of blood to the head. Stimulation of the sympathetic causes the secretion to become cloudy. Section of the fifth has been observed to be followed by paralytic secretion.

The quantity of tears secreted is believed by Magaard‡ to be at the rate of one drop per twenty minutes. They are clear, watery, alkaline, and of saline taste. The composition of the tears probably varies in different people, but the

fluid usually contains only 1 per cent. of solids, the chief salt being sodium chloride.

*Luxation.*—That, well protected as the lacrymal gland is, it may be luxated either by external violence or by disease developing in the deeper parts of the orbit, is demonstrated in various cases that have been reported. One of these is given by Dr. Rampoldi\*, in which a blow with a stick in the temporo-parietal region was followed in the course of a month by the formation of a retro-bulbar abscess. An opening was made at the upper and inner part of the orbit and the pus evacuated; a drainage-tube was inserted and antiseptic injections employed. The exophthalmos subsided, and there was no impairment of vision. Osteo-periostitis with a fistulous passage formed, and gradually ectropion took place; the lids became quite everted, and so much retraction occurred that the gland was gradually luxated from its position and drawn down till it appeared beneath the conjunctiva. Finding that he could not replace it, M. Rampoldi destroyed it by the plan suggested by Borelli to remove staphyloma. A case has been recorded by Snell,† and another has been met with by v. Graefe,‡ in which prolapse of the gland occurred as the result of an injury. It is to be taken as a matter of course, for v. Graefe replaced it in its natural position, applied a suture or two to the eyelid, and cured the patient.

*Dacryo-adenalgia.*—Persistent pain of the lacrymal gland, long ago diagnosed and described by Schmidt under the term "dacryo-adenalgia," is characterised by severe tension and lancinating pain in the region of the gland. Intolerance of light is experienced, but there is or may be no suffusion of the conjunctiva. The chief symptom appears to be great increase in the quantity of secretion discharged, which in one instance reported by A. Schmidt amounted in twenty-four hours to no less than 2lb. 7½ oz. In such cases the lids are apt to become sore. A scrofulous inflamma-

\*Arch. f. Mik. Anat., B. xvii., p. 1.

†Handbuch der Physiologie, B. v., p. 90.

‡Virchow's Archiv. B. lxxxix., p. 253. See also Gad., Dubois Reymond's Archiv, Suppl., 1883, p. 72.

\*Annali d'Ottal., an. xiii., fasc. 1.

†Ophth. Rev., vol. 1.

‡Archiv f. Ophth. 1886, B. xii., p. 224.

tion of the globe of the eye extending to the gland may be the primary cause of this lesion. The affection increases gradually in intensity, and has no tendency to run into suppuration. It occurs most frequently in children, in women, especially in the puerperal state, and may be the consequence of undeveloped gout. The conditions that cause or, at least, intensify it are exposure to bright light, disturbance of the cutaneous or other secretory organ, mental excitement, and great variations of temperature. The prognosis is, on the whole, favorable; but the affection is liable to become chronic, and relapses are apt to occur.

The treatment consists in the application of heat, care being taken not to arrest the secretion too suddenly lest violent inflammation supervene. Hence, warm ethereal or spiritous applications are best, especially poultices of ethereal plants, infriktion of mercury and of camphor, with or without opium. The general treatment is of still greater importance, and the remedies applied must be adapted to restore the bodily health of the patient. Locally, a solution of five grains of watery extract of opium to an ounce of water, with spirit of chamomile, compresses of lukewarm water, renewed every hour, and poultices of alum or zinc sulphate, are the applications recommended by the authors I have mentioned.

I have seen one case of this disease in a stout woman age sixty. The pain was accompanied by violent itching, which caused her to rub the eyebrow so much that she had rubbed off all the hairs. She attended the hospital at intervals for several years and a great variety of remedies were tried for her, both local and general, but without effect. No causes could be ascertained for the affection.

*Dacryo-adenitis.* — Inflammation of the lacrymal gland is undoubtedly a rare disease, both in acute and chronic form. Arlt\* states that he has never seen a case of it. Desmarres† observes that in a large practice extending over

many years no example had fallen under his notice. Deval,‡ perhaps with more accuracy, states that he has never been able to diagnose a case. Hirschberg\* says that he only saw one case of suppurative inflammation of the gland in 22,000 cases. Galezowski,† during the four years he was chief de clinique to Desmarres, saw no example of it. Lawrence‡ observes: "I do not remember having seen either of these affections" (acute or chronic inflammation), and he thinks he must have either overlooked diseases of this organ which have been noticed by others or have mistaken them for other affections. Nevertheless, in support of his own observation, he goes on to say that in twelve of the annual reports of diseases treated at the London Ophthalmic Infirmary, embracing a total of 40,000 cases, the lacrymal gland is not even mentioned in the list of diseases. There is only one case of abscess of the lacrymal gland referred to in the indices of the Royal London Ophthalmic Hospital Reports. Beer, whose practice was very large, only saw it a few times in the course of twenty-seven years. Velpeau, commenting on the exceptional rarity of inflammation of the lacrymal gland, compares it with the pancreas in respect. He had seen three cases of the disease.

It is not difficult to assign reasons why inflammation of this gland should be of exceptional occurrence, for it occupies a position that is remarkably protected both from injury and from cold. Then, again, the product of secretion is of so limpid and watery character that concretions from inspissation or deposition are extremely rare, whilst it is discharged by ducts which, though very fine, are yet numerous, and perhaps communicate so that there is little risk of secretion being retained. Indeed, an arrest of the discharge of tears, either by constriction or occlusion of the ducts, is very rarely seen even by those who have large opportunities of treating ophthalmic diseases, and I only know of one instance

\*Maladies des Yeux.

\*American Journal of Ophthalmology, 1879, p. 369.

†Recueil d'Ophth., 1881, p. 65.

‡Treatise on Diseases of the Eye, 1844, p. 798.

\*Lehrbuch.

†Traité des Maladies de Yeux, 1854, p. 262.



where congenital absence of tears has been observed. This case was a child exhibited by Mr. Standford Morton to the Ophthalmological Society on Jan. 10th, 1884. No tears had ever been seen to flow from the right eye. The difficulty that is experienced in diagnosing inflammatory affections of this gland from inflammation of the lids and of the connective tissue of the orbit, hinted at by Mr. Lawrence, is occasioned by the depth at which it is situated below the surface, and by the swelling of the lids which accompanies any inflammation at the upper and outer part of the orbit, which renders it difficult to determine whether the gland is really swollen or not. Nevertheless, however rare in the practice of some surgeons, it has occurred with much greater frequency in that of others. Schmidt, for example, who wrote a treatise on the disease of the lacrymal organs, met with and described many cases; Todd had the same fortune; Travers\* says that the gland often suppurates in children. Lawrence, in alluding to these cases, sarcastically observes that he has met with some recorded cases in which inflammation and supuration of the lacrymal gland are *said* to have occurred. "The mischief began in these instances with a blow. I believe them to have been merely abscesses of the lid; at least, I see no circumstances to prove that the lacrymal gland was involved in the affection."

Galezowski, in the memoirs just referred to, reports nine cases that have occurred under his observation, and he notices that they presented an epidemic character; for whilst he only saw one case in each of the years 1869, 1873, and 1880, there were no less than six in 1875, and in this year mumps was prevalent. It is probable that this affords some clue to the varied experience of different surgeons, and some support is given to it by the history of a case reported in the Transactions of the American Society of Ophthalmology two years ago by Pooley,\* which is suggestive in this direction. The interesting

and unusual feature in this case was the occurrence of an acute inflammation of the gland during the course of an acute diphtheritic inflammation of the other eye, raising the question in my mind whether it might not have been caused by septic absorption. In the discussion which followed the reading of Dr. Pooley's paper, however, Dr. Knapp observed that the cases he had seen had no infectious origin, and in the majority of cases there was no conjunctival complication.

In acute inflammation of the lacrymal gland, the patient, after suffering from chills and general malaise for a day or two, experiences sharp lancinating pains in the region of the gland extending over the side of the head and towards the parotid gland, which is usually swollen and tender. The conjunctiva is either dry or moister than natural, and the swelling of the gland causes the globe of the eye to be displaced downwards and inwards, so that the squinting and diplopia occur. Any rolling movement of it is painful, and it is sensitive and tense. There is usually considerable redness and swelling of the upper lid, especially near the outer angle, and this occasions a mechanical ptosis, the patient being unable to raise the lid. It is tender to the touch. In the earlier period of the disease the margin of the gland can be recognized as a hard resistant border, with a groove between it and the margin of the orbit, and at this period, on raising the upper lid, the gland may be seen to project into the conjunctival sinus. At a later period the swelling of the lid is too great to allow the gland to be either felt or seen. The conjunctiva is generally red, inflamed, and chemosed, especially near the outer canthus. If the disease develop rapidly, the symptoms described by some authors probably occur—such, for example, as cerebral excitement, sleeplessness and delirium, which have been attributed in part to the pain, and in part to the implication of the dura mater. Himly† who speaks as though the affection were of common occurrence, remarks that the symptoms

\*Synopsis, 1824, p. 233.

\*Trans. Ophth. Soc., 1884, and Archives of Ophthalmology, vol. xiv., p. 162.

†Die Krankheiten des Auges, B. I., 1843, p. 279.

of the acute stage are followed by a period when the stabbing pain ceases, whilst the tension still remains extraordinarily great and a feeling of pressure and of cold is experienced. The pressure of the swollen gland interferes with the function of the optic nerve, and photopsiæ or luminous phenomena and impairment of vision have been noticed, both probably arising from mechanical pressure upon the optic nerve. After a few days suppuration takes place, and gives rise to a feeling of fluctuation beneath the skin and orbicularis, though it ultimately bursts near the outer angle or into the conjunctival sac.

The causes to which it has been attributed are rheumatism, sudden exposure to cold, especially in gouty subjects—as, for example, immersion in cold water whilst heated and perspiring; and Schmidt, Travers, and Galezowski consider that children of a scrofulous habit of body between the ages of seven and twenty are especially liable to it. In Galezowski's seven cases, however, the ages were sixteen, twenty-six, twenty-six, twenty-seven, forty-eight, and fifty-six—ages which do not bear out the above statement. Of these cases four were males and three females. I have seen three cases at least, and these were all in women; one was twenty-four, the second thirty-four, and the third forty. Acute inflammation of the gland has been observed to recur. Fulton† gives a case of acute primary inflammation of the lacrymal gland occurring twice in the same individual. The patient was a woman aged twenty. No cause could be assigned for the affection. An interval of three years occurred between the attacks. Both attacks subsided under general and local antiphlogistic treatment: leeches, hot compresses, and iodide of potassium. In some fortunate cases the inflammation terminates in resolution, and the patient suffers no further inconvenience, the swelling gradually diminishing, and the eye, if affected, resuming its function. In other instances the acute inflammation subsides, but is succeeded by chronic enlargement and

tenderness. In still other cases suppuration takes place in the course of a week, and recovery follows, though usually with some secondary trouble, such as the formation of a fistula or a puckered cicatrix and retraction of the upper lid, and not infrequently considerable impairment of vision.

As regards treatment, the abortive plan may be tried in the early stages of the inflammation, with the view of preventing the occurrence of suppuration. An emetic may be administered, and after it has acted a mixture containing quinine and iodide of potassium should be prescribed. Locally, the best means to employ are six to eight leeches to the eyelid, and lotions containing belladonna and acetate of lead, or the upper lid may be brushed over two or three times with iodine tincture. When the pain is very severe opium should be given. When it is clear that pus has formed, the earlier it is opened the better for the patient. As already stated, a delicate sense of touch is required to recognize the presence of pus when deeply seated and covered by such a tissue as the oedematous eyelid, and little benefit accrues from plunging a knife into the gland whilst the abscess is still immature. Travers\* states that the abscess, when it has matured, may be conveniently discharged beneath the lid with a narrow curved bistoury. Himly† on the other hand, recommends that the abscess be opened through the skin with a lancet, the flat surface of which is kept parallel with the fibres of the orbicularis; and he maintains that owing to the swelling of the lid it is seldom possible to open it through the conjunctival sinus, though he was on one occasion able to accomplish it. A tent soaked in boracic acid may be left in the wound, even when it has been opened under very strict antiseptic methods, in order that the cavity of the abscess may granulate from the bottom. In many instances the inflammation has been so violent that the margin of the orbit or the orbital plate of the frontal bone is necrosed, and the abscess, instead of healing completely,

\*Loc. cit., p. 233.

†Loc. cit., p. 279.



ends in the formation of a fistulous passage, into which a probe may often be passed for a considerable depth, and then strikes on rough and exposed bone. Under these circumstances a free incision should be made, and the diseased bone brought into view, and if possible gouged or rasped away. When, however, the orbital plate of the frontal bone is necrosed, it must be left alone till it has completely separated. It must be remembered that the plate is very thin, that the substance of the brain cortex is in very close proximity, and that laceration of the surface, or its penetration by splinter of bone, or even the mere entrance of pus into the vessels and into the cavity of the cranium, might be attended with fatal results. In some cases the fistulous opening appears to communicate with one of the ducts of the gland, and in that case a minute opening appears upon the skin or upon the conjunctival surface, from and through which a clear transparent fluid constantly distils in drops. This affection is termed "dacryops," or true lacrymal fistula.

Non-suppurative acute dacryo-adenitis, which has been termed "mumps of the lacrymal glands," is also rare. Hirshberg reports a case occurring in a girl aged fifteen. There were bilateral swelling and injection of the upper lid, without chemosis or lacrymation. The swollen glands could be distinguished by palpation. Poultices and iodide of potassium were prescribed. Moderate chemosis subsequently occurred, and the right globe was displaced, causing diplopia. This state was persistent. The chronic form, according to Hirschfeld,\* is not so exceedingly rare, but is generally secondary. It originates in scrofulous patients with protracted keratitis and profuse lacrymation. A reddish tongue-shaped swelling, with granular surface, becomes visible between the upper lid and the eyeball towards the outer canthus when the patient rotates the eye downwards whilst the lid is raised.

## Society Reports.

### TRANSACTIONS OF THE FIRST MEETING OF THE GERMAN GYNECOLOGICAL ASSOCIATION.\*

HELD AT MUNICH, JUNE 17TH, 18TH, AND 19TH, 1886.

REPORTED BY M. WIENER, M.D., Breslau.

#### *First-Day.—Morning Session.*

*President*, DR. WINCKEL, Munich.  
*Secretary*, DR. KUESTNER, Jena.

*Dr. P. Mueller* (Berne) read a paper on

#### THE AFTER-TREATMENT OF GRAVE LAPAROTOMIES.

Among the dangers after laparotomy, disturbances from the intestinal tract deserve special attention. They occur not rarely after ovariectomy, and are frequently connected with operation, in that inflammatory processes take place around the pedicle, or some intestinal loops become adherent to the wound or raw surfaces. Of especial gravity are those cases in which extensive raw surfaces must be left at the operation, as where large portions of the intestines have to be detached. Under such circumstance, firm adhesions occur when the intestines are kept quiet. The reader witnessed two cases of death from this cause (symptoms of incarceration). These adhesions might be prevented to a certain extent, if we could omit the compressive bandage, for then the raw surfaces are pressed together; but we cannot do without these dressings in order to avoid after-hemorrhages. Yet where the hemorrhage is not to be feared the permanent dressing could be dispensed with. Moreover, we could prevent such adhesions of the intestines to each other and to the abdominal wall by isolating these parts, for instance, by injecting into the abdominal cavity fluids which keep the parts separated in the first few days after the operation.

\*Amer. Arch. of Ophth., 1878, p. 369.

\*From the American Journal of Obstetrics.

The fluid must be aseptic, non-irritating, must have no toxic influence, must be readily absorbable or removable. Such a fluid we have in a sterilized 0.7 per cent. solution of table salt. In one case, the reader injected 2,400 gm., which only at first was followed by disturbances (rise of pulse and respiration). These phenomena were symptoms of absorption, not by sepsis. This overfilling of the circulating and overtaxing of the heart might perhaps be avoided by injecting smaller quantities of the salt solution from time to time, and, if necessary, allowing the fluid to escape through the drainage tube which must remain.

*Dr. Olshausen* expressed surprise at the number of cases in *Mueller's* practice; he had known adhesions to occur after the introduction of iodoform into the abdominal cavity; he had always observed adhesions of the intestinal loops to the pedicle, and only once adhesions of the loops to each other; this led to symptoms of peritonitis without the occurrence of ileus. All cases of ileus are due to adhesion to the pedicle; if we wish to prevent this accident, we should like *Thornton*, stitch the pedicle to the vesico-uterine fold of the perineum. The idea of injecting salt solution he held to be rational, especially if hemorrhage had occurred; in which event it would be better, instead of transfusion, to make injections into the abdominal cavity. After injecting large quantities of thymol he had noticed some symptoms of shock, perhaps symptoms of intoxication; experience would have to decide which.

*Dr. Schatz* had observed adhesions after laparotomy despite a favorable course; he believed such adhesions to be more frequent than would appear, even when symptoms are absent. These adhesions need not be serious; after some time the intestine again becomes pervious; for such cases opium should be employed, since the obstruction portion cannot always be found after opening the abdomen.

*Dr. Kaltenbach.*—In time past, cases of intestinal obstruction were more frequent than nowadays; probably, he formerly believed, owing to the careful toilet which irritates the intestines and

causes axial rotation; besides, the antiseptics employed might scrape off the epithelium. At present he is of a different opinion; he ascribes the adhesions to insufficient disinfection; he introduces sponges but rarely into the abdominal cavity; for this he uses sublimate. Since then he had seen no more incarceration. Among twenty-four cases treated with carbolic acid, he observed three times symptoms of intestinal occlusion (two of them fatal); now, among fifty-seven cases he had not had any.

*Dr. Gusserow* had frequently, during the earlier operations, observed adhesions of the intestines to the anterior abdominal wall without any symptoms having shown themselves. He does not ascribe this to the toilet.

*Dr. Krukenberg* called to mind the case formerly published, in which adhesions had taken place after sublimate treatment. Since he had given up the use of the sublimate, he had not seen any more cases of ileus. As regards adhesions to the anterior abdominal wall he believes that the turning out of the tumor through the small incision causes minute hemorrhages between the abdominal wall and the peritoneum, as well as detachment of epithelium.

*Dr. Elischer* (Budapest) thinks that he avoids adhesions to the pedicle by sewing it over and over with catgut; in such cases he has never seen adhesions of the pedicle to the intestine. He has, however, had a case of rupture of the stomach in chronic gastric catarrh; after sixteen hours the peritoneum was firmly adherent and for this reason he believes the cause to lie in detachment of the epithelium.

*Dr. Meinert* (Dresden) had observed a fatal case due to adhesions. After an ovariectomy a remnant of a cyst had been dropped into the abdominal cavity. A year later, the operation had to be repeated, as the tumor enlarged again. The intestine was wounded and sutured. There was a linear adhesion of the intestine to the abdominal wound.

*Dr. Kuestner* thought that adhesions might possibly be prevented by the running catgut suture of the peritoneal surface.

*Dr. Saenger* did not believe that the



salt solution would prevent adhesions, because the fluid would be absorbed in a short time, before the regeneration of the wound surfaces had commenced. One raw surface suffices to bring about adhesions. At all events, adhesions are not dangerous, are of frequent occurrence, and are not always the causes of ileus. He had seen ileus due to large peritonitic exudation; in another case nothing was found but tympanitic distention and ulceration of the stomach; he believed this due to septic intestinal paralysis. In this case injection into the abdominal cavity would have availed nothing. Finally he referred to the experiments he had made in connection with his paper on the resection of the peritoneum.

*Dr. Mueller* remarked that he had used sublimate for two years, and had observed the symptoms in that time.

*Dr. Schrawz* did not believe that detachment of the epithelium was a cause; if this were so, adhesions should be found in other places where it is of equally frequent occurrence. He believes that the cause of the adhesions lies in the form of the abdominal cavity and the irritation of the epithelium. The abdominal suture produces an excavation in which the intestines are situated. This facilitates the occurrence of adhesions.

*Dr. v. Sæwinger* defended carbolic acid and thorough disinfection in reply to *Dr. Kaltenbach*. Among one hundred and thirty-one cases he had observed no intestinal occlusion.

*Dr. Kaltenbach* looks upon sublimate simply as an agent which more readily protects against purulent peritonitis.

*Dr. Firnig* (Cologne) has observed no case of intestinal occlusion during three years in Bardenheuer's practice, who uses a 5 per cent. solution of carbolic acid. He ascribes occlusion to infection (perhaps by specific carriers), which leads to adhesion. He recommends, wherever possible, incapsulation of the field of operation towards the abdominal cavity, and then to let the operation follow (junction of the round ligaments with the anterior abdominal wall, then enucleation of the tumor).

*Dr. Gusserow* denied the assertion of the last speaker; it was not necessary to invent special microbes for adhesions; minor injuries sufficed.

*Dr. Bayer* (Strassburg) read a paper on

#### PLACENTA PREVIA.

*Duncan's* theory as regards hemorrhages in placenta previa was formulated to apply only to the hemorrhages occurring with the pains and suffices for these alone. Since that time we have learned of the formation of a lower uterine segment. This is not simply the lowest portion of the uterus, but a zone, characterized by quite definite qualities, which does not take part in the contractions, and depends after labor on a condition of extreme relaxation. The hemorrhages have been brought into connection with the development of this lower segment, and since the latter forms during pregnancy, this apparently explains also the hemorrhages occurring during gestation.

The reader then compared the various views respecting the origin of the lower uterine segment with the conditions existing in placenta previa. According to the views of those who look upon the lower segment as a portion of the body of the uterus, the placenta previa must be partly or wholly inserted into the segment. But this is a physiological impossibility, at least in cases terminating favorably, for, owing to the absence of contraction or retraction of the placental site in the lower segment, every parturient with placenta previa would be hopelessly doomed to death from hemorrhage. The other view, according to which the lower segment forms from the supravaginal portion, explains the phenomena in a less forced manner. But then the questions arise, why does hemorrhage not invariably occur during pregnancy and why can the placenta be felt occasionally immediately over the closed cervical canal, or one with opened parallel walls? These objections cannot be explained by saying that the conditions vary in different cases. The reader concludes from the observation of twenty cases that in pla-

centa previa similar conditions prevail as in premature labor, that is to say, that in that condition the defective development of the supravaginal portion is a typical phenomenon; that furthermore the internal os occasionally remains closed until the actual commencement of labor, and that in that case no lower segment is formed.

The reader distinguishes:

A. Simple low insertion where the margin of the placenta reaches only into the neighborhood of the internal os. Here hemorrhage occurs only during labor, when a portion of the placenta remains in the area of relaxation, *i. e.*, when the lower segment is not formed normally. Accordingly the reader found low insertion of the placenta with hemorrhage during delivery only in premature labors in the eighth or ninth month.

B. True placenta previa. To constitute this condition, it is necessary that some portion of the placenta at some time covers the internal os. There is only a difference in degree between placenta previa centralis and lateralis; the former may pass into the latter in the course of pregnancy or not until labor, when the supra vaginal portion develops accordingly; inversely, the symptoms of placenta previa centralis may be present, although only a small lobe projects over the internal os, when the latter did not dilate materially before the examination. As the internal os opens, the placenta inserted upon it must become detached or it must tear; in either case hemorrhage occurs. If this takes place during pregnancy, provided the latter continues after the first hemorrhage we must expect alterations in the placenta. In the cases observed by the reader, such alterations were constant when hemorrhage had occurred previous to labor; they are always absent when the first hemorrhage took place at the onset of true contractions. The reader distinguishes:

1. Hemorrhages during pregnancy; they characterize cases in which the os opens during pregnancy.

*a.* The placenta remains firmly on its seat, while the portion on the os inter-

num tears; the laceration may extend to the membra chorii; in this case labor will probably set in soon or the child die from loss of blood.

If the internal os opens very gradually, more superficial lesions of the placenta may arise; according to the view of the author, a placenta marginata occasionally forms by the tearing apart of the placenta, flattening and relatively excessive spreading of the maternal surface.

Perhaps such lacerations or tearing apart of the cotyledons over the internal os explain also the cases of placenta succenturiata.

*b.* When the internal os opens, the smaller lobe of the placenta is loosened; it falls into the lower segment which develops only to a slight degree; it becomes exsanguinated, flattens, atrophies, and detaches itself from its chorionic insertion. This form of placenta, therefore, can be looked upon as a partial placenta marginata.

Should the pregnancy continue long enough after the detachment of the smaller lobe, it is possible that a lower segment of normal extent will form subsequently; if the placenta at the same time is situated at the anterior wall, it will possibly be no longer palpable during labor as previa, and in some cases not give rise to hemorrhage even during the pains.

2. Hemorrhages during true contractions. Here Duncan's explanation is valid. The uterus draws itself upwards at the placenta so long as the ovum remains intact. In this way, a larger and larger portion of the placenta appears free; the lobe thus detached looks thick, saturated with blood, bluish-red, and covered with clots. If it was the source of hemorrhage before or during pregnancy, there are besides corresponding alterations in the placenta.

In rarer cases, the internal os remains closed until the onset of labor. Then there is an absence of those changes in the placenta which require time for their development, but there is also an absence of every uterine hemorrhage during pregnancy, and more dangerous for mother and child.



a. The unfolding of the cervix during the pains progresses in a normal. In such cases the manipulations of the attendant are rendered more or less difficult, and the ordinary cervical lacerations—longitudinal tears through the lower portion of the neck—occur more readily. The first hemorrhage is then usually of special severity, as Spiegelberg has formerly pointed out.

Of much graver import are the cases in which the still undeveloped supravaginal portion shows a tendency to form a stricture—placenta previa stricture. In such cases, the internal os remains comparatively narrow during the pains, while the inferior portions of the cervix dilate in form of an ampulla. The author has met with a similar case in which the parturient lost no blood, not only during pregnancy, but even for two days during labor, although placental tissue was situated all around over the internal os. Immediately after labor, the patient bled to death from a fistulous cervical laceration extending as far as the peritoneum. The reader proposed the following divisions:

1. Placenta previa with corresponding development of the supravaginal portion and hemorrhages during pregnancy and alterations in the placenta.

The reader observed ten cases with hemorrhages during pregnancy; among these were two cases of placenta marginata totalis, six of partial placenta marginata, two of placenta succenturiata. Eight children were born living, one at six months, one dead. All mothers recovered.

2. Placenta previa with cervix remaining intact until the onset of true labor; no chronic alterations in the placenta, no uterine hemorrhages during pregnancy.

Aside from three cases of low insertion of the placenta and hemorrhage with premature labor, the reader had observed seven cases of placenta previa without hemorrhage during pregnancy. In six of those, labor occurred at term. Two children were born living, five dead; one mother died of hemorrhage immediately after labor, one had a severe attack of parametritis, one required the suturing of the cervix.

*Dr. Schatz* thought that many more examinations must be made in order to clear up the relations in question. The formation of the placenta is at present much earlier than the activity of the uterus; it takes place at a time when it is impossible to speak of hemorrhages and lacerations.

*Dr. Kuestner* spoke of the annulus fibrosus which stands in close connection with placenta previa. In the case of the annulus fibrosus we have to deal not with fibrous formations, but with coagulation necrosis (*Ackermann*), perhaps also with hemorrhages which subsequently undergo alterations. The thick chorionic membrane which unites the cotyledo succenturiata is likewise due to coagulation necrosis, and not to detachment. The annulus fibrosus prevents the growth of the placenta beyond it.

*Dr. Bayer* found placenta marginata most frequently at the tubal angles, and gave a mechanical explanation of it. It is usually semilunar in shape.

*Dr. Schatz*.—The idea that the placenta is unable to grow further may be correct; but we find placenta which have no ring, and still do not grow further; in proof of this, he cited the twin placenta of a single ovum.

*Dr. Veit* (Berlin).—*Kuestner* has changed his view, as may be learned from the discussion at the Magdeburg meeting of German Naturalists and Physicians; in the formation of the placenta, the essential point, is, how the white ring arises. Before a coagulation necrosis begins, other processes must be present; he believed that they are processes affecting the decidua; he laid the greatest weight on the white ring, and thought that the growth beyond the placenta is possible. He inquired whether *Bayer* was basing on anatomical or clinical observations when he asserted that the placenta does not lie in the lower uterine segment.

*Dr. Hofmeier* spoke of the development of the lower segment in placenta previa, and would not admit the lower segment does not expand; he believed that this question could be solved only by anatomical preparations. Thus, uteri which he had examined anatomically in

placenta previa showed a lower uterine segment very well developed. Contractions of the lower uterine segment are not necessary for the arrest of hemorrhage in placenta previa, as Simpson's experience teaches. The question is mainly where the uterine vessels enter the muscular structure; in one specimen he found that the larger vessels entered at the point where the peritoneum is firmly attached. Hence contractions of the lower segment are not necessary.

*Dr. Kuestner* did not believe in primary inflammatory processes of the decidua, as there were not sufficient data at hand in support of it. The main point was a coagulation necrosis.

*Dr. Bayer.*—The *margo* of the placenta marginata is a secondary feature. To Hofmeier he replied that he did not doubt that a lower segment forms; the question is only whether the lower segment develops during labor. As regards the site of placenta previa below the prominence due to contraction, he doubted whether in these cases a normal lower segment had formed.

(To be continued.)

## THE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

HELD AT BRIGHTON, ENG., AUG. 12, 1886.

*Telegraphic Letter from Brighton to the N. Y. Med. Jl., Aug. 14, 1886.*

The British Medical Association has been favored in its fifty fourth annual meeting, now drawing to its conclusion here, by the prevalence of beautiful weather, the judicious and thoughtful arrangements made by the local executive committee, and a large attendance, including that of many foreign guests, among whom Americans are prominent. First among the entertainments was a reception given by the Mayor of Brighton on Tuesday, the opening day of the meeting. The address delivered by the president, Dr. Withers Moore, of Brighton, dealt largely with the "higher education" of women—or, rather, that form of their education which aims to put

them into men's shoes—and in particular with the damage to their health and their fecundity caused by excessive brain work, both in its immediate bearing upon the women of the present day and in its prospective influence in bringing about a deterioration of the race. The competition of women with men was unwholesome; the force action of their brain which was considered "progressive" incapacitated them in great measure both for the proper performance of their bodily functions and for the form of mental work which was peculiarly their own by nature. Dr. Moore was quite positive in the expression of these views, and backed them up by pointing to American experience as exemplified in the writings of Clarke, Emmet, and Loomis, and to the observations of Tuke, Crichton Browne, and others. At the conclusion of the address a vote of thanks to the president was moved by N. S. Davis, of Chicago.

On Wednesday your distinguished countryman, Dr. Billings, delivered the Address in Medicine. As I understand that you are to publish it, I will make no further remark than to say that it completely fulfilled the anticipations of the audience, and greater justice could not be done by it. The Address in Surgery was given by Professor Frederick Abell Humphry, surgeon to the Sussex County Hospital. Recent advances had been greater, he thought, in the domain of operative procedures than in that of the medical treatment of surgical diseases, the most notable achievements of the latter being the use of anesthetics and that of antiseptics. With regard to antiseptics, he attributed their chief power for good to their preventing decomposition rather than to their preventing fermentation due to germs. As noteworthy examples of the predominance of scientific knowledge in controlling and directing advances in the treatment of disease, both medical and surgical, Mr. Humphry alluded to Hilton's essay on "Rest and Pain" and to Pasteur's experimental investigation of hydrophobia and the possible means of preventing it.

In the Section of Surgery, the presi-



dent's address. by Mr. John Eric Erichsen, of London, related to the advances made in surgery since the introduction of anæsthetics. These, he said, included: 1. An extension of the scope of surgery, with improvements in its methods. 2. Increased precision in the performance of operations and greater certainty as to their results. 3. The promise of a wider application of scientific methods of research in the future. The address of the president of the Section in Obstetric Medicine, Dr. Alfred Meadows, of London, dealt largely with the alternatives of craniotomy and with the operation of removal of the uterine appendages. Dr. Meadows advocated the entire abolition of craniotomy, and recommended Porro's operation as preferable to the Cæsarean section, more especially as it effectually precluded the subsequent occurrence of impregnation. Removal of the uterine appendages he looked upon as undoubtedly a sound procedure in appropriate cases, but it was to be feared that its too frequent performance was among the results of the surgical tendencies of the present day, which were too apt to lead to the neglect of scientific therapeutics in gynecology. In the Section in Psychology, the president, Dr. Thomas Smith Clouston, of Edinburgh, spoke in his address of the relation of bodily pain to mental suffering. After referring to Meynert's theory, he directed attention to the close connection between melancholia and neuralgia. Bodily pain preceded melancholia; and there was a state of mental analgesia succeeding an acute melancholic attack of neuralgia. Mental and bodily pain could not co-exist in great intensity, but in hypochondriasis they co-existed in moderate degrees.

The address by the president of the Section in Ophthalmology, Mr. Charles Oldham, of Brighton, while welcoming the members, reminded them that the last Brighton meeting of the association had been held in 1851, the year in which Helmholtz invented the ophthalmoscope. The speaker then enumerated the advances of the past year, alluding particularly to our improved knowledge of sympathetic ophthalmia and simple glau-

coma, to the use of cocaine, to suppuration after operations for epiphora, to the use of antiseptic precautions in ophthalmic surgery, and to the extension of ophthalmological knowledge among non-specialists. Mr. G. F. Hodgson, of Brighton, the president of the Section in Otology, gave an address reviewing the progress of aural surgery during the present century, showing that, while virtually it had no existence before that time, it was now fully abreast of the other branches of the healing art. As a consequence, some knowledge of it should be diffused among general practitioners.

To-day (Thursday), the Address in Public Medicine was given by Dr. E. D. Mapother, of Dublin. Dr. Mapother spoke first of efforts to abate the smoking nuisance, particularly of the necessity of suppressing the escape of smoke from private chimneys, and advocated the gradual compulsory introduction of smoke-consuming grates, also Cooper's method of purifying gas by using limed coal. The decrease in the death-rate, he said, was chiefly attributable to sanitation, especially in the matter of the mortality of infants less than a year old from diarrhœal diseases. The speaker then made suggestions as to infant feeding from a preventive point of view, and as to the precautions to be taken to prevent the spread of scarlet fever by milk, the disease being communicable to cows by inoculation. The address before the Section in Medicine, by the Dr. W. H. Broadbent, called attention to the desirability of looking beyond the immediate results of treatment and the necessity of forethought in the employment of remedial measures. The president alluded to the habitual frequent suppression of gouty manifestations as leading to accumulation of nitrogenized waste-products with high arterial tension—results which were also produced by Bantingism, by rigid dietetic methods of treating diabetes in elderly persons of a gouty habit, by the relief of asthmatic paroxysms with solanaceous powders, and by attempts to cure sick headaches by means of low diet and purgatives.

The American delegation present, in-

cluding Dr. Davis and others, made a statement before a crowded general meeting in regard to the affairs of the International Medical Congress. The delegates were received with enthusiasm, and their renewed invitation to the members of the association to visit Washington in 1887 was cordially accepted.

THE CONNECTION BETWEEN SCARLET FEVER AND HEART DISEASE.—Dr. Henry Ashby has made a study of 900 cases of scarlet fever which have been treated at the Children's Hospital, Manchester, during the past five years (*The Lancet*). The question is raised as to the part played by the virus of scarlet fever in exciting or predisposing to an attack of rheumatism. The commonest form of joint-affection which complicates scarlet fever in children is of a form of synovitis, but it is very rarely accompanied by endocarditis. These attacks differ in many ways from acute or subacute rheumatism—they are more fugitive in character, rarely recurring or returning to a joint when once it has left; and exhibiting an especial tendency to attack the synovial membranes on the backs and palms of the hands, finger-joints, soles of the feet, and cervical vertebræ. The attacks mostly take place from the seventh to the ninth day of the fever. Apart from synovitis, attacks undistinguishable from true rheumatism are liable to occur at the end of the third or during the fourth week, much at the same time as nephritis are liable to supervene. This post-scarlatinal rheumatism is commoner in young adults than in children, and in these attacks endocarditis is by no means uncommon. Cases recovering from rheumatic fever, and then attacked with scarlet fever, often suffer from a relapse of the rheumatism; but in what way the poison of scarlet fever determines the relapse in these cases the author cannot say definitely. Nephritis following scarlet fever is a not infrequent cause of cardiac lesions. A certain amount of dilatation of the left ventricle, with more or less compensatory hypertrophy, occurs in most cases of scarlatinal nephritis of

any severity. Both endocarditis and pericarditis may take place, and occasionally embolism occurs. Occasionally pyæmia complicates scarlet fever, and then periendocarditis often accompanies the attack, which is generally fatal. No doubt in some cases of scarlet fever there is some dilatation of the heart, but this does not amount to anything of consequence unless there be nephritis as well. In acute nephritis, however, dilatation may take place very quickly, and yet no murmur is detected; and, even when a murmur has been found, the author says he has seen no evidence at the post-mortem examination of endocarditis. This dilatation may be perfectly recovered from, but many cases end fatally.—*Med. Record*.

IODOL IN SURGICAL PRACTICE.—Dr. Gaetano Mazzoni ("Ctrlbl. f. d. ges. Ther.") obtained from his assistant in the laboratory a new chemical preparation named iodol, which apparently has the same properties as iodoform. It is a yellowish powder, tasteless, and with scarcely any smell. The drug was applied either as a powder, or suspended in glycerin, or in the form of an ointment with vaseline. In venereal sores it gave brilliant results. It was applied in the same way as iodoform is commonly applied. In other than venereal sores, iodol showed itself efficacious. It was used with good results in gangrenous and atonic ulcers, but was found useless in necrotic and highly gangrenous ulcers. In a case of hypertrophic lupus it was employed in the form of injections into the surrounding subcutaneous tissue with the effect of preventing the spread of the affection. An alcoholic solution of iodol injected into the joint in three cases of fungous disease of the ankle joint caused the disappearance of the vegetations in a relatively short course of time and effected a cure. In conclusion, the author remarks that in no case treated by iodol did erysipelas or diphtheria make its appearance, and in cases of diphtheria evoked by mercurial treatment the employment of iodol caused a rapid disappearance of that affection.—*N. Y. Med. Jl.*



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BALTIMORE, AUGUST 21, 1886.

## Editorial.

THE ETIOLOGY OF TYPHOID FEVER.—Recent methods of investigation have demonstrated many diseases to be infectious whose true nature was hitherto only suspected.

For a period of about fifteen years contributions have been received from various sources bearing upon the infectious nature of typhoid fever. Different organisms have been described as present in the tissues involved during the progress of the disease, and supposed by their describers to possess etiological relations to the pathological process. But their describers have brought in support of their views simply that these organisms were seen in the tissues, failing to produce the all essential factor in the proof of such an assertion—the result of successful cultivation and inoculation experiments made with the organisms described by them. And hence it was not until the publication of Fränkel and Simmonds that we were justified in accepting as established that typhoid fever is an infectious malady depending upon an organism that can be cultivated in artificial media and which is then capable of producing the disease when inoculated into animals. Possessing then the knowledge that this disease depends upon a microorganism for its origin, and having at command a means of isolating and cultivating this organism, it is not presuming upon this knowledge to hope that later investigations may supply a

means of successful vaccination against its invasion.

In 1871 Recklinghausen (*Wurzburg Zeitung*, 1871,) described a micrococcus that he found in the inflammatory products of typhoid fever. In 1875 Klein described, in the Reports of the Medical Office of the Privy Council and Local Government Board, a micrococcus that he found in the inflamed mucous membrane of the intestinal canal, the lymph follicles and the blood vessels of typhoid fever cases. In 1876 Socoloff (*Zur Pathologie der Acute Milztumor*) found micrococci present in only 3 out of 12 typhoid spleens examined. His examination of the lymph glands gave negative results. In 1878 Fischel (*Über das Vorkommen von Micrococci in einigen Organen bei Typhus abdominalis*, *Prager med. Wochen.*, 1878) described colonies of micrococci that he found in the spaces of the splenic tissues. He speaks of them as resembling, in their locality and arrangement, the emboli of septic micrococci resulting from septic infection, although he states they are not so sharply circumscribed, being closely packed at the centre of the mass and lying loosely in the tissues at the periphery. He states that they do not always lie in the vessels but are seen in the stroma of the organ. In 1880 Klebs (*Arch. f. exp. Pathol.*) described a bacillus that he thought to be the cause of typhoid fever. In the examination of 24 cases he claims to have found the organism described by him in all of them, either in the intestinal ulcerations, the mesenteric glands or in the tissues of the spleen. In the same year (1880) Eberth, (*Virch. Arch.*, Vol. 81) in referring to an organism in typhoid fever, says that it is a bacillus and not a micrococcus as was supposed by a number of writers previous to the time of this publication. He thinks their error due to the fact that these observers examined the organism in masses, when a short rod will often given rise to deception and appear as a spherical body. He relates 23 cases, in 12 of which he found the bacillus described by him. In a later publication (*Virch. Arch.*, Vol. 83, 1881) he found the organism in 6 additional cases. In 1884 Gaffky (*Mit-*

theil a. d. k. Gesundheitsamte) published the result of a series of 28 post-mortem examinations made upon subjects dead of typhoid fever, in 26 of which he was enabled to demonstrate in either the mesenteric glands, the spleen, the liver or the kidneys, a short, oval organism, the description of which corresponds so closely to that of the bacillus described by Eberth in this disease, that there is left but little room for doubt that the two organisms are identical. Of the 2 cases of the 28 in which he failed to find the organism in the above named organs he remarks, that in the first case, an examination of 146 sections of these organs failed to reveal the bacilli, but, upon examination of the intestinal tract, he there found evidence of old ulcerations and likewise recent necrotic changes, and it was in the latter that he detected, not only superficially, but deep down in the tissues beyond where the ulceration had extended, characteristic masses of these bacilli. He offers no explanation for the presence of the organisms in the intestines and their absence from the other tissues. His second negative case was one in which he hardly expected to find the organisms, as the patient died during the fourth week of the disease, not from the typhoid process as such, but from a consequent perforative peritonitis, all acute evidence of the malady having passed away.

In 1885 Fränkel and Simmonds ("*Zur Ätiologie des Abdominaltyphus*," *Centralbl. f. Klin. Med.*, 1885, No. 44) published the results of their experiments upon this disease. Their efforts were not so much to describe an organism present in the tissues of subjects dead of this malady, as to prove whether or not the organisms already described had any real claim to the etiology of the disease. They investigated, by Koch's plate method, the fresh spleens of 12 cases dead of typhoid fever, and in each instance were able to isolate in pure cultures the identical organism described by Eberth and by Gaffky. Examination of the blood of these 12 cases failed to demonstrate the presence of the organism in 6 of them. The bacilli were present in the stools of 3 out of 7 cases

examined. Inoculation of pure cultures of the organism into the vein of the ear of 27 rabbits gave positive results in 15 cases. Of 20 inoculations into gray house mice 14 were successful in producing the disease. After injection into the peritoneal cavity of 3 guinea-pigs one died of the disease. The results of all these inoculations appeared in from a few hours to three days. The symptoms most prominent in their appearance were loss of appetite, and a pronounced diarrhoea lasting until death.

At autopsies made upon animals that had died of the disease the following changes were observed:—acute swelling of the spleen, enlargement and hæmorrhagic discoloration of the mesenteric glands, enlargement of the axillary and inguinal glands, and swelling of Peyer's patches. In one case there was observed a single spot of enlarged follicles in the intestine, which was covered by a recently produced patch of necrotic tissue. By Microscopic examination of the fresh spleen pulp, and likewise hardened spleen tissue of all these animals, as well as cultivation experiments made from the fresh material, the bacilli were proven to be present.

The fact that a disease so prevalent in our latitude at certain seasons of the year as typhoid fever is of parasitic origin, and that the organism which is proven to cause it may be demonstrated in the evacuations of these patients; we think of more than ordinary interest as suggesting a line of action in the practice of preventive medicine. If the removal from the premises of the intestinal evacuations as soon as they have been passed, and their careful disinfection be insisted upon, there can be but one result—the lessening of the number of new cases. The hygienic value of such a precaution, especially in localities where the excretions are simply thrown upon the ground to pass off by natural drainage or to be destroyed by the processes of decomposition, is apparent. While the neglect of this precaution must result, first, in the contamination of the earth, and later, the water supply.

If careful examination be made into the source of most epidemics of this



malady, especially those occurring in the rural districts, it will be found that in the majority of instances the origin can readily be traced to just such causes.

As the season for the appearance of intestinal troubles, and especially typhoid fever, is rapidly approaching, we feel at liberty to direct attention to this bit of hygiene, believing that if faithfully carried out the result will be plainly seen in the diminution of the number of cases and spread of this disease.

### Miscellany.

**BILIOUSNESS.**—In an editorial article on this subject the *Boston Medical and Surgical Journal* says: "The treatment of biliousness is prophylactic, alimentary and medicinal. Prophylaxis is concerned with avoidance of all the known causes, whether of a toxic, malarial or alimentary character. A plain diet, of bread, milk, oatmeal, vegetables and fruits with lean meat or fresh fish in moderation, and abstinence from alcoholic stimulants seems to be the ideal fare for the biliously predisposed. This kind of diet is especially applicable for hot weather when albuminoids are apt to clog the portal system, and pastries are an abomination, and when a broiled schrode, a little chicken or mutton broth with bread and stewed fruit will make a more healthful meal than the more sumptuous fare of a modern fashionable dining-saloon.

Exercise in the open air is of recognized utility in promoting oxidation and elimination, enhancing the digestive and assimilative processes, and lightening the burdens of the liver. Moreover, exercise (whether by rowing, horseback-riding, gardening, walking) hinders absorption of bile by the hepatic venous radicals, and promotes the passage of that fluid into the duodenum, through the increased compression exerted on the liver by the diaphragm and abdominal muscles; this is in accordance with a recognized physiological law.

The victim of an acute bilious attack will generally get righted in a few days by, first, abstinence from all food, then

a diet of porridge and milk, or skimmed milk alone, and a very gradual return to solid food, which for several days should be restricted to toast, a little lean meat, or broiled fish, with some succulent vegetable or ripe fruit. As for medicines, saline aperients, such as sulphate of soda, epsom or rochelle salts in full doses in the morning, or the now fashionable tumblerful of hunyadi janos will generally suffice to clear the *primæ viæ*; the latter has especially a reputation for evacuating bile. The striking relief obtained by free bilious evacuations has often been remarked, and the veteran transgressor resorts to his blue pill or podophyllin with every recurrence of his malady. Of late enonymin has come much into use as a cholagogue.

Harley recommends to persons who seem to have a more than usual tendency to biliousness traceable to sluggish biliary secretion, and where there seems also to be defective nerve action, small doses of nux vomica or strychnia after their meals. This may be combined with belladonna and aloes as in the aloin, strychnia and belladonna pill. The bilious person is generally constipated, hence such a pill has special utility. Fothergill's pill of ipecac, capsicum, and pil. aloes et myrrh, has done good service in such cases. Nitro-muriatic acid and taraxacum have a reputation which is probably not altogether built on imaginary results. But bilious dyspeptics, while they should be attentive to the functions of eliminations (and doubtless the ancient predilection for purgatives has been justified by modern scientific research which finds in intestinal septicæmias and alkaloids of putrefaction, many of the evils formerly attributed to peccant humors and atro-biliary disorders, should aim especially to be good hygienists and learn to live right, but this is counsel which everybody gives and no body takes."

**THE TREATMENT OF RABIES WITH HOANG-NAN.**—The Paris correspondent to the *Lancet* writes: "According to the *Gazette Médicale de Nantes*, twenty-cases of rabies have been treated with Hoang-nan by Dr. Barthélemy and seve-

ral other medical men of that city or of the department. The first case so treated was in the month of March, 1882, the last in April, 1885. Ten times, at least, the bites, which were most frequently multiple, were situated on the hands, once on the hand and on the face. In the majority of cases cauterisation was completely omitted, or practised several hours or even several days after, with agents little active, such as liquid ammonia or a solution of carbolic acid. Two of the patients, who were closely observed by Dr. Barthélemy,—viz., a man of thirty and a lad of sixteen—presented symptoms of rabie mania: persistent insomnia, anxiety, nocturnal agitation, the desire to run, hallucinations, barking, &c. However, none of these persons felt hydrophobic, nor have any of them, to this date, succumbed. The duration of this preventive treatment was, on an average, twelve days. The total dose of the powder of hoang-nan ingested during this time, varied in adults from six to eight grammes. It was scarcely necessary to go beyond one gramme per day to obtain the physiological effects of the medicine—exaggeration of reflexes, cramps, rigidity, slight trismus. The maximum dose was arrived at progressively, and in some cases the treatment was terminated by gradually decreasing doses. From the above cases the author deduces either that rabies is communicated much more rarely to the human species than is generally admitted, or that the hoang-nan, administered progressively to the physiological effects *during the period of incubation*, sufficiently and efficaciously modifies the nervous system and the entire economy to prevent the evolution of the rabie virus.

**DIURETIC MIXTURE FOR GOUT.**—J. Mortimer Granville, in his recent work on *Gout in its Clinical Aspects*, discards the usual diuretics as irritants, the indication being to “flush” not to stimulate the kidney. For this purpose the most available drugs are ammonium chloride and potassium chlorate. At the same time the decomposition of the so-

dium urate in the blood may be attempted, and to this end Dr. Granville considers iodine best adapted, exhibiting it with the salts and glycerine, as exemplified in the following formula:

R. Ammonii chloridi . . . 3 iv,  
Potassii chloratis . . . 3 ij,  
Tinct. iodi . . . . . ℥ cxx,  
Glycerini . . . . . 3 iss,  
Aquæ . . . . . ad 3 xvj. M

F. Mistura, cujus sumantus cochlearia duo magna quartâ quâque horâ ex aquâ.—*Canada Lancet*.

**TREATMENT OF ACUTE TONSILITIS.**—Dr. John Brown states, in the *British Medical Journal*, that it is a rare event for suppuration to occur in acute tonsillitis, if treated early with the following mixture:

R. Sodii salicylat. . . . . 3 iss.  
Pot. bicarb. . . . . 3 iss.  
Tinct. aconit. . . . . ℥ 40.  
Liq. opii sed. . . . . ℥ 30.  
Sp. chloroform . . . . . 3 ii.  
Aq ad . . . . . 3 viii. M.

One ounce to be taken every two or three hours for the first thirty-six hours. The same mixture is his sheet anchor for rheumatic fever.

**HEADACHE CURED BY SALICYLATE OF SODIUM.**—The action of drugs in megrim and gout is remarkably similar. Trousseau and others have used colchicum with benefit in megrim, and other observers have remarked on the similar curative effects that certain purgatives, as calomel, have in both gout and megrim; and, again, others, have used pot. iod. with considerable success; but the great value of salicylate of sodium in some of these headaches is more remarkable still; it seems to be most certainly curative and not merely palliative, as it removes the concomitant gastro-intestinal troubles along with the headache. Thus, a dose of brom. pot. and sp. ammon. aromat. will sometimes remove a slight headache, but it will probably return; with salicylate treatment it is quite a different matter, the headache is gone once and for all, and shows no sign of return for a considerable period; its ac-



tion in this respect is very similar to that of calomel, and, like calomel, it seems to free the secretions of the mouth, and, at the same time, slightly relaxes the bowels.

The dose of salicylate used is two to three grains every quarter or half hour for three or four doses or more, as recommended by Dr. Brunton, and begun when the headache first comes on; this is sufficient. A patient might carry dr. i of the powder in his pocket and take a little when a headache threatens, and he would soon learn to judge the proper dose by sight.

And as to diet, from which meat, cheese, beer, wine, and spirits are absent, we will only say that experience has more and more convinced us of its value in such cases.—*London Practitioner*.

**BACTERIA-THERAPY.**—Dr. Fras. Troup has recently satisfied himself that a sputum which has putrified for fourteen months still contains tubercle bacilli, which are capable of reproducing their kind; and therefore, the good results of spraying with *bacterium termo* must be attributable to some other cause.—*Brit. Med. Jour.*, June 19, 1885.

**LAPAROTOMY FOR ACUTE SUPPURATIVE PERITONITIS.**—At a meeting of the Zurich Medical Society, Professor Kroenlein reported three cases of laparotomy for acute diffuse purulent peritonitis. One of his patients, a lad aged seventeen, with perforation of the vermiform appendix, died from collapse two days after the operation. Another, a man aged sixty-one, with perforation of the small bowel and extreme collapse, survived only a few hours. But the third patient, aged eighteen, made a satisfactory recovery, though his state at the time of the operation was extremely grave.—*Brit. Med. Journ.*

## THERAPEUTICAL NOTES.

(From the *N. Y. Med. Jour.* Aug. 7, '86.)

**Viburnum Prunifolium as a Preventive of Abortion.**—Cheron (*Gaz. de gynécologie*, July 1886) recommends the following:

Tincture of viburnum prunifolium 40 minims;

Elixir of garus,\* - - 1 ounce;

Simple Syrup. - - 1 ounce;

Distilled water - - 2 ounces.

A tablespoonful every hour, or half hour, as required.

**A Soothing Injection for Acute Vaginal Inflammation.**—Trousseau (*Ibid.*) is credited with this combination:

Belladonna leaves, - ½ ounce;

Stramonium leaves, - ½ ounce;

Water - - - 1½ pint.

Boil away one third of the water and then add thirty drops of laudanum. In cases of carcinoma uteri, where the pain is excessive, two or three drachms of laudanum may be used.

**An Emmenagogue Powder.**—Potain (*Ibid.*) uses this formula:

Powdered artemisia leaves, 38 grains;

Powdered milfoil, - 38 grains;

Powdered saffron, - 19 grains.

Mix and divide into five powders. In cases of amenorrhœa, give one powder daily for five days before the expected period.

**A Remedy for the Pigmentation of Pregnant Women.**—Monin (*Ibid.*) recommends the use, night and morning, of an ointment having the following composition:

Cocoa-butter, - 2½ drachms;

Castor-oil, - 2½ drachms;

Oxide of zinc, - 3½ grains;

White precipitate - 1½ grains;

Essence of roses, - 10 minims.

**Hæmstatic Pills.**—To Huchard (*Ibid.*) is attributed this formula:

Egotin, - - 30 grains;

Sulphate of quinine, - 30 grains;

Powdered digitalis, - 3½ grains;

Extract of hyoscyamus 3½ grains;

Make twenty pills. Dose from five to ten daily in cases of metrorrhagia.

\*Consisting of the compound tincture of saffron and an aromatic. The former contains aloes, saffron, cinnamon, cloves and nutmeg, and is used as a stomachic.

### Medical Items.

Dr. T. H. Nott, of Goliad, was elected President of the Texas State Medical Association at its late session in Dallas.

Dr. Edward Warren Bey, of Paris, has been named one of the vice-presidents of the International Medical Congress which meets in Washington in 1887.

Dr. William L. Dudley, late of Miami Medical College, Cincinnati, has accepted the Chair of Chemistry in Vanderbilt University, Nashville, Tenn.

Dr. Moxen, one of the most prominent physicians connected with Guy's Hospital, London, a friend and associate of the late Hilton Fagge, died suddenly on the 21st of July.

Professor Graskey, of Würzburg, has been called to Munich, to be the successor of the late Professor Von Gudden, whose sad death by drowning has recently been commented on.

O. Langendorff, in the *Neurologische Centralblatt* for 1885, No. 24, has determined, by careful experiment, that the chemical reaction of the gray substance of the brain is, in all instances, naturally alkaline, contrary to the opinions previously held.—*Neurological Review*.

The Brighton prize of two hundred dollars for the current year has just been awarded, by the committee appointed for that purpose by the President and Fellows of Harvard University, to Dr. Charles F. Withington, of Boston, for an essay on "The Relation of Hospitals to Medical Education."

**ETHER-TIGHT CORKS.**—Corks may be rendered perfectly ether-tight by coating them with a solution prepared from four parts of gelatine, fifty-two parts of boiling water, and one part of ammonium bichromate (added to the filtered gelatine solution) and then exposing them for a few days to sunlight.—*Ex.*

By the death of Dr. Walter Moxon, which occurred suddenly on the 21st inst., the medical profession loses a distinguished leader, a brilliant writer, an eloquent speaker and an unsurpassed teacher. Esteemed by all with whom he came in contact, his untimely decease is keenly mourned by his professional and private friends. In our next issue we purpose giving a detailed *résumé* of his life and work.—*Lancet*, July 31.

On account of the meeting of the International Medical Congress in Washington, on September 5, of next year, the meeting of the Seventh International Congress of Hygiene and Dermatology at Vienna, which has been fixed for the second week in September, 1887, has been postponed to the end of the month, in order that those who desire to participate in both Congresses may do so.—*Med. Times*.

Instances of extreme old age are reported from Russia. The *Novosti*, a Russian journal, announces the death, in the almshouse of St. Petersburg, of a man aged one hundred and twenty-two years, who had been an inmate since 1818. His mental faculties were preserved up to the time of his death, and his general health was excellent to the age of one hundred and eighteen, when he commenced to fail. There is in the same institution a soldier's widow, who, as shown by documentary evidence, is at least one hundred and ten years. In our own country, at New Holland, O., Mrs. Arnold has just celebrated the one hundred and ninth anniversary of her birth; and her two sisters are still living, aged respectively one hundred and six and one hundred and twelve.—*Boston Med. and Surg. Journal*.

The meeting of the British Medical Association, held at Brighton during the past week, was a successful gathering of the British profession. It is also remarkable in the fact that the address in medicine was delivered by an American, Dr. J. S. Billings, who selected as the subject of his remarks, "Medicine in the United States and Its Relation to Co-operative Investigation." Dr. Billings' address was well-received. Dr. N. S. Davis, of Chicago, was introduced as a delegate to the Association and President of the International Medical Congress. Papers were read by Dr. T. A. Emmet, of New York, and by Dr. J. V. Shoemaker, of Philadelphia. Upon the whole the attention bestowed upon American medicine and upon the American profession is an indication of a growing feeling of respect between the professions of these two great English-speaking races.

Dr. Frank H. Hamilton, the well-known surgeon and author, died at his residence in New York City, on August 11th, with phthisis pulmonalis, from which he had suffered for several years. Dr. Hamilton was born in Wilmington, Vermont, on September 10, 1813. He was graduated from the University of Pennsylvania at the age of 20 years. Soon after graduation he entered upon active and earnest work and very early gave promise of the distinguished career he subsequently achieved. In 1847 he became professor of surgery in the University of Buffalo, and for 14 years held this Chair. He removed to Brooklyn and became the first Professor of Surgery in the Long Island Hospital Medical College, which position he resigned in 1861 to accept a position as surgeon in the U. S. Army. He became Medical Inspector of the U. S. Army in 1863. He was one of the founders of Bellevue Hospital Medical College, and held the Chair of Surgery until 1875, when he resigned. Dr. Hamilton was a widely-known medical writer. His work on "Fractures and Dislocations," and his "Treatise on the Principles and Practice of Surgery," are recognized textbooks on these subjects. He will be remembered in history as one of the consulting surgeons in President Garfield's case.



Selected Articles.

ON THE EARLY DIAGNOSIS AND TREATMENT OF SYPHILIS.\*

BY FESSENDEN N. OTIS, M.D.,

Clinical Professor of Genito-Urinary Diseases at the College of Physicians and Surgeons, New York.

Authorities are not wanting to claim the early excision of the initial lesion of syphilis as efficient in wholly preventing constitutional infection. Auspitz and Kolliker, of Vienna, the former in 1877, and the latter in 1878, reported cases, (in all about forty) where such excision was believed to have been effectual in preventing the occurrence of constitutional syphilis. It was even stated that in several of these cases enlargement of the adjacent lymphatic glands was already well marked at the date of the operation.

The fact that many cases of syphilis pass through the active stage of the disease without any recognized external manifestations beyond the initial lesion and the adjacent gland enlargements is well authenticated. The localized accumulation of infective cell material, constituting the earliest salient feature of the initial lesion of syphilis, warrants the belief that its complete destruction, by excision or cauterization, would inevitably prevent infection *if it could be accomplished before the infective material had passed beyond the part so destroyed*; but it is more than probable that within a very short time after inoculation the infective cells are carried into lymph spaces and channels far beyond the reach of caustic or knife. Bumstead's experience in fifteen cases† is in proof of this; also Berkeley Hill's‡ case, where deep cauterization a few hours after inoculation failed to prevent general infection. And yet a personal experience in a large number of cases (over thirty) where the initial lesion of syphilis was excised at various periods from the date of inoculation has brought

the conviction that, while it is practically useless—for reasons previously given—as a prevention of general infection, it had yet proved a most valuable measure. In several cases large indurated and ulcerated lesions, which had been rebellious to treatment for several months, were removed by excision, the wound healing by first intention without subsequent induration. The prolonged observation of such cases has also brought the conviction that, while excision is practically powerless to prevent constitutional infection, the persons so treated are as a rule less liable to severe forms of the lesions of the active stage of the disease. The absolute removal of a mass of vitiated cell material, which would otherwise remain to re-inforce the infective process, also gives support to such a belief.

The cases most favorable for excision are those where the neoplasm is situated on loose tissue—movable and non-ulcerating. If inflamed or suppurating, antiphlogistic applications until this is subdued, and subsequently thorough disinfection with a bichloride (1 to 1,000) or carbolic solution (1 to 40) should immediately precede the operation. Raise the mass of induration between the forefinger and thumb, encircle it firmly with a bit of fine silver or malleable iron wire, being careful to include all the abnormal tissue. Now, with a narrow, sharp-pointed bistoury pierce the centre, beneath the wire, and cut well under and out, including all the indurated and a little of the sound tissue of that side. In the same way remove the affected part on the opposite side, and close the wound with a deep, fine, continuous suture, preferably of iron-dyed silk. Apply a light dressing of lint wet with carbolated water or lotio plumbi et opii, and keep the patient in a recumbent position until the third day. The stitches may then be removed, and as a rule union by first intention will be found to have taken place.

When the initial lesion is simply abraded, and for any reason, such as its situation on the glans penis or because the patient is indisposed to the use of the knife, any inflammatory condition

\*From the *N. Y. Med. Monthly* for August, 1886.

†"Venereal Diseases" Bumstead and Taylor. Fifth edition.

‡Hill and Cooper. London, 1881. Page 76.

should first be met by the use of sedative lotions and rest. Freed from irritation, the only obstacle to prompt healing is the presence of the cell accumulation, which acts as a mechanical hindrance to the circulation at the affected point.

It is this same cell accumulation which, by this same hindrance in various localities and the irritation consequent upon it, causes all the variations and complications which determine the form and condition of the initial lesion. Aside from the accidents of local irritation, which must always be met by rest and sedative appliances, our only object should be to remove the abnormal obstructive living cell material, of which the disease we are combating practically consists. Living cell material can only be removed through fatty degeneration or metamorphosis, and its subsequent absorption be effected. The most active and reliable agent in effecting this is mercury in some form, in some way. Administered either externally or internally, we have a known means of accomplishing the removal of the infective cell material of syphilis wherever situated. Clinically this has been understood for a very long period, and the approved treatment accepted by all authorities to-day, for every and any stage or form or manifestation of syphilis, wherever situated, is by mercurials chiefly—often solely. The internal administration of it is found more serviceable than its local use, even in the cure of the simplest as well as the most pronounced form of the initial lesion, as combating the disease in its progress beyond the local lesion, and on its way the lymph channels and glands to the great lymphatic reservoir—the receptaculum chyli—through which the diseased cells find their way into the general circulation, and are thus carried to every part of the economy.

All the approved local applications for the cure of the initial lesion of syphilis (after it has been freed from local irritation) are composed of some form of mercury. Dusting with dry calomel, application of the *lotio nigri*—which simply consists of a drachm of calomel

to a pint of lime water—or the *lotio flavio*, which is made by adding half a drachm of the bichloride of mercury to a pint of lime water. These, including the *ung. hydrag.*, with an equal part of simple ointment, or a 5-per cent. solution of the oleate of mercury, constitute the chief and only specific local measures by which we expect to hasten the cure of the initial lesions of syphilis.

The lotions are most appropriate to the cure of the open initial lesions, and the unguents to the indurations left after healing. But it is never sufficient to treat a well-determined initial lesion of syphilis locally alone. The internal administration of this drug, so beneficent in its effects when judiciously used, is always indicated, excepting only in those rare and unfortunate cases where syphilis has occurred in a subject of highly scrofulous diathesis, and even then we are at a loss to find a substitute which will justify its complete omission.

In all cases it should be used in the treatment of the initial lesion of syphilis with a clear understanding of the purpose for which it is to be administered. Not as an antidote to a hypothetical virus, the nature and composition of which we are ignorant; not as a specific even, but as a known agent in causing the fatty degeneration, absorption and elimination of the degraded cell material which constitutes the active agent in disturbing the organism of a person affected with syphilis; and it should be used from the moment of inoculation until the active stage of the disease has passed. This peccant cell material of syphilis is always hastily generated, and holds its life by a feeble tenure than the material composing the cells and tissues of which the normal human organism is composed; and hence such an amount of mercury should always be used as will effect the fatty metamorphosis of the syphilitic product without materially and unfavorably acting on the healthy cells and tissues. Small doses of mercury, long continued, have been found clinically and empirically to cure syphilis, beginning with the initial lesion and continuing it during a period which experience has shown to be necessary to



effect its entire elimination from the affected organism. The form which may be used is not material, so only that it is such as is best suited to the digestive peculiarities of a given case. Perhaps the one generally best borne is the pill composed of mass hydrarg. Of this two grains, combined with the exsiccated sulphate of iron, one grain, administered once a day for a few days in cases of initial lesion, then two per day for a few days, then increasing to three, and if no digestive disturbance occurs, such as indigestion or intestinal irritation—producing looseness of the bowels—such quantity may be continued until every vestige of the lesion has disappeared. This accomplished, the further administration of mercury or its equivalent will be required in some other form, either by the mouth, by the skin through inunction, or by fumigations, until the contagious stage of the disease has passed. The chief indication in carrying on this method of treatment is to administer the remedy in such a judicious way that none but the slightest evidences of mercurialism shall occur, and these only at long intervals. Such evidence appearing once in three or four months will give assurance that the treatment is efficient. Slight sensitiveness of the gums or the teeth, slight mercurial taste or fœtor of breath may be looked for, and should be accepted as the extreme limit, just below which, as the rule, it should be the aim of the judicious physician to keep his patient. Gastric or intestinal irritation should be met by diminishing the dose in the first place. Then, if not enough to produce the desired effect can be taken without friction, some other form should be tried—perhaps the necessary equivalent in mercury with chalk. The pill of protiodide may also be used. If still the irritation ensues, then the plan of treatment by inunction should be practiced. This may be effected by rubbing in from one to two drachms daily of mild mercurial ointment (ung. hyd. et ung. simp., part eq.), on any part of the body, in places as free from hair as possible, and over a surface of half a square foot or more. If applied by an attendant (protecting

his hand by a kid glove) the back is preferable. The part well warmed, the application should be continued for fifteen to twenty minutes, shifting place at each inunction in order to avoid irritation of the skin. A general warm soap bath may be given once a week, also when any sign of mercurialism occurs this should be given, and the treatment temporarily suspended.

The inunction of a 20-per cent. solution of the oleate of mercury with an equal part of simple ointment, and perfumed by a few drops of the oil of bergamot, is equally efficient, perhaps a little more irritating, but, requiring less time, is well adapted to the use of patients who find it convenient to apply it for themselves.

In the administration of mercury, by this or any other plan, the physician should be on the watch for any sign of mercurialism, and, if found, omit the treatment until it has passed off. A gargle of the chlorate of potass., rinsing the mouth with it morning and night, should be used, and the teeth kept scrupulously clean while the treatment is in progress. The early treatment of syphilis is just that, practically, which is called for during the entire course of active or contagious stage of the disease, with the simple difference that in former the local conditions require a consideration of changes which are the result of purely local influence.

### Society Reports.

#### TRANSACTIONS OF THE FIRST MEETING OF THE GERMAN GYNECOLOGICAL ASSOCIATION.\*

HELD AT MUNICH, JUNE 17TH, 18TH, AND 19TH, 1886.

(Continued from last issue.)

REPORTED BY M. WIENER, M.D., BRESLAU.

*First-Day.—Morning Session.*

*President, DR. WINCKEL, Munich.*  
*Secretary, DR. KUESTNER, Jena.*

\*From the American Journal of Obstetrics.

*Dr. Fehling* (Stuttgart) read a paper on

THE RELATIONS BETWEEN THE QUALITY OF  
THE BLOOD IN THE PREGNANT FEMALE  
AND THE COMPOSITION OF THE  
LIQUOR AMNII.

Looking upon the liquor amnii as a maternal transudation, the reader had asked himself the question whether it would not be possible to find relations between the chemical composition of the blood and the liquor amnii. To this end, the liquor amnii was analyzed quantitatively, also its dry residue, albumin, and ash. In the blood of the gravida, the quantity of hemoglobin was ascertained by means of Fleisch's hemometer, and the number of blood-corpuscles counted.

Taking the quantity of hemoglobin, according to Fleisch, at 100 per cent. in healthy men and at 93 per cent. in healthy women, there were found variations of hemoglobin in gravidæ from 67 to 110 per cent; in two-thirds of the cases examined (about one hundred) it was less than 100 per cent. Repeated examinations of the blood of the same gravida showed generally an increase of the hemoglobin with the advance of pregnancy—a result which conflicts with earlier investigations by Andral and Gavaret, Nasse, and others.

The increase finds its explanation probably in the vigorous nutrition, in the same way as the decrease of hemoglobin usually found post partum is explained by the loss of blood during labor. The greatest decrease was to 41 per cent. in placenta previa. The number of red blood-corpuscles amounted to between three and four millions, on the average, less than Ingerslev found. The rise and fall in the number usually corresponded with the increase and decrease of the quantity of hemoglobin.

No constant relation could be found between the quantity of liquor amnii and the amount of hemoglobin of the gravida; but it was found, as before, that the dry residue is independent of the quantity of liquor amnii. Hence the liquor amnii is not simply diluted to-

wards the end of pregnancy. The dry residue of the liquor amnii depends directly on its albumin contents, the amount of ash remains nearly constant.

Furthermore, there was found a proportional relation between the amount of hemoglobin in the blood and the quantity of albumen in the liquor amnii, the albumen in the liquor amnii increasing with the rise of hemoglobin contents in the blood of the gravida, viz., with a quantity of hemoglobin averaging 106 per cent. it equalled 0.21 per cent; and of hemoglobin 80 per cent. it equalled 0.15 per cent. Finally, the amount of albumen in the liquor amnii seems to be somewhat larger in ripe than in premature ova. In these results the reader finds a further support for the view that the liquor amnii is to be considered in the main as a maternal transudation.

*Dr. Krukenberg.*—The increase of albumen in the liquor amnii may be due to alterations in the fetal blood, and need not depend on the increase of hemoglobin in the maternal blood. To be sure, according to his investigations, there were no urinary casts in the liquor amnii, while they are present in the fetal urine. His experiment of tying the uterine vessels to cause uterine stasis had been barren of results as regards the source of the liquor amnii. He held that Fehling's explanation that the liquor amnii was chiefly a maternal transudation, was possible, but not proven.

*Dr. Gusserow* remarked that he no longer as strictly maintained his former standpoint. Ultimately the liquor amnii comes, of course, from the maternal blood; for although the fetus really adds its urine to the liquor, this portion was likewise derived from the maternal blood.

*Dr. Prochownick.*—The chemical processes do not suffice; he would recommend, besides, physico-experimental investigation. He had recently experimented with the fetal membranes, allowing a current of fluid to pass; nothing had penetrated.

*Dr. Schatz* pointed to the condition of hydramnios in the case of some twins, and expressed belief that nature here



showed the source from which the fluid was derived.

*Dr. Fehling* had not yet examined the hemoglobin contents of the fetal blood. He did not intend his statements to be demonstrative, but merely to support his view. In reply to *Prochownick*, he remarked the dead membranes have different results from living ones.

*Dr. Weiner.*—According to the investigations of *Zuntz* and *Cohnstein*, the hemoglobin contents of the fetus steadily increase with its progressive development; hence the larger quantities of albumen in the liquor amnii during the later months of pregnancy might also be derived from the fetus. At all events it had been proven experimentally that the membranes are more pervious in the later than in the earlier months of pregnancy. This fact might perhaps explain the larger amount of albumen in the liquor amnii in advanced pregnancy, but proved nothing against an admixture of fetal urine. In this respect, we dare not deny some influence due to the activity of the fetal kidney which has also been proved experimentally. Moreover, the case of urinary stasis accompanying occlusion of the urinary passages of otherwise healthy ova indicate a regular activity of the fetal kidney, in other words, an admixture of the urine to the liquor amnii.

*Dr. Runge* stated that *Alex. Schmidt*, who had examined the blood of the child at the moment of birth, had not found any material alteration of the hemoglobin contents of the fetus during labor.

*Dr. Prochownick* said in reply to *Fehling* that the membranes which he had used were quite fresh and as like the living ones as possible.

*Dr. Saenger* (Leipzig) read a paper on

PALPATION OF THE URETERS.

He referred to his paper recently published in the *Arch. f. Gyn.*, XXXVIII, 1, and gave the previous history of the subject, in which *Hegar* and *Chrobak* take a prominent part, and in connection with palpation of the ureters in diseases of the urinary organs he stated

that case 2 described in that paper (cysto-utero-pyelitis duplex) had meantime died, and the diagnosis made during life, of greater implication of the right side, was fully confirmed at the autopsy. He spoke of making the diagnosis of diseases of the bladder and kidneys from the vagina, of palpating the ureters in the pregnant female, with healthy and morbid sexual, but normal urinary organs. He also discussed the frequent occurrence of epithelioma from the renal pelvis in the urine from inflammatory and thickened ureters, and finally contrasted the sounding of the ureters (perfected mainly by *Pawlick* and his ingenious method) with the brief ligation of the ureter, not according to *Hegar* after exposure of the ureter by a vaginal section, but without the latter operation, after having marked the ureter through *Simon's* speculum under the direction of the eye. Palpation of the ureter, however, will certainly restrict this procedure and even the necessity for the separate collection of the urine from one kidney.

He exhibited three gravidæ and two gynecological patients in whom the ureters could be felt in the most satisfactory manner.

*Dr. Winkel* remarked that *Heldebrand* had previously demonstrated the protuberance of the ureters in retroflexion of the uterus.

*Dr. Hirschberg.*—It is not possible to distinguish the epithelium of the renal pelvis from that of the bladder; therefore it cannot be decided whether catarrh of the renal pelvis or of the bladder is present; sounding likewise gives no information in the case of calculous kidney.

*Dr. Chrobak* has also stated before that the ureters are palpable. *Pawlick* is likewise in the habit of palpating the ureters.

*Dr. Schwarz* had repeatedly palpated the ureters and thinks the procedure easy. Where difficulty is encountered, he fills the rectum with the colpeurynter so as to have a foundation on which the ureter can be felt. He preferred the direct method (examination with *Simon's* speculum) to that of *Saenger*. In this

way he had repeatedly seen turbid urine flow from one ureteral orifice, and clear urine from the other. Through Simon's speculum he had several times sounded the ureters; it is only necessary to fix the orifice with a tenaculum.

*Dr. Olshausen.*—In order to determine whether one or the other kidney is diseased, we can omit ligation and content ourselves with compression of the ureters; the latter can certainly be compressed with a clamp-like instrument from the vagina, and this can be done for some length of time without bad results.

*Dr. Korn* (Dresden), among one hundred cases of pregnant women, had failed only once to palpate the ureters. In one case of chronic vesical catarrh he had felt both ureters to be as thick as a lead pencil.

*Dr. Elischer.*—Palpation of the ureters is important, especially with reference to the extirpation of the uterus; he had made a ureteral fistula in his first extirpation. Sounding *per se* is not so difficult as the penetration beyond the angle formed by the vesical portion of the ureter with the upper part. He thought ligation of the ureters was not free from danger.

*Dr. Mundé* doubted whether the ureters could really be distinctly felt, or whether other structures might not be mistaken for them. In chronic disease of the bladder the thickened ureters could be felt, as he had convinced himself in one case.

*Dr. Zweifel.*—Compression of the ureters had been spoken of already by Tuchmann and Simon; this he believed to be most convenient. The compression forceps are applied to the vesical orifice of the ureters.

*Dr. Krukenberg.*—After ligation of the ureters nephritis may occasionally arise (Aufrecht).

*Dr. Saenger.*—Hegar only mentioned palpation of the ureters in general, as did Chrobak. Besides Hildebrand's statement, which seems to refer solely to retroflexion of the uterus, nothing is said anywhere respecting the almost regular palpability of the ureters and its applicability to the diagnosis of diseases of the

urinary organs. Not the mere finding of epithelium from the renal pelvis, but its occurrence in large numbers and pronounced character, together with evidence of disease of the ureters, he believes to prove implication of the renal pelvis. In this paper he had already proposed compression of the ureters instead of ligation wherever possible. Ligation of short duration would hardly produce nephritis. Sounding of the ureters as practiced by Schwarz he would characterize as antiquated hereafter, when contrasted with Pawlick's method. Mistaking other structures for the ureters is out of the question if we bear in mind the anatomical relations. Attention must be devoted only to those inferior portions of the urinary organs which are palpable from the vagina, then they will often be felt with surprising clearness both in health and disease.

*Dr. Schwarz* did not intend in every case to dilate and use a tenaculum for the purpose of sounding the ureters; had done so only in one case.

#### *Afternoon Session.*

*President, Dr. WINCKEL.*

*Dr. Zweifel* (Erlangen) exhibited an

#### APPARATUS FOR THE FILTRATION OF LIQUIDS CONTAINING BACTERIA,

in connection with the following paper:

When pregnant women suffer with infectious diseases, it is well known that the ovum does not escape the infection. Of course, there is a great difference in the several forms. While variola hardly ever spares the child, the ovum may escape the infection in some of the other diseases.

Nothing is known in regard to typhus fever, but with reference to measles and scarlatina, however contagious they may be otherwise, we know of no instances of transmission. To be sure, the last-named disease cannot be properly compared with variola because they are mainly diseases of childhood, and a single attack nearly always secures immunity, and secondly, because it is possible for



the fetus to pass through the entire disease in utero, but continue to develop and be born without showing a trace of having been affected.

There is, however, a disease which shares the special position of variola—splenic fever. Davaine inoculated pregnant animals with its infectious principle and the fetuses escaped the affection. Similar results have been published by Bollinger.

Up to a few years ago, this fact seemed to harmonize very well with our experiences regarding the transition of solid, liquid, and gaseous bodies from the maternal to the fetal organism. The demonstration of liquid and gaseous bodies in the fetus succeeded, that of solid bodies failed. The circumstances have changed in every respect during the last few years; solid bodies, including the spirillum of remittent fever and even the bacillus anthracis, were found in the fetuses of the infected maternal animals.

At any rate, this difference still exists that the contagium of variola extends very rapidly, other infectious matters more slowly, to the fetus.

Three years ago, when he was still impressed with experimental labors then known, he explained the difference to himself thus, that the poison of variola is soluble, while that of the other diseases is inclosed in cells. In order to test this, he filtered lymph through porous clay, in imitation of the clay-cell filtration introduced by F. W. Zahn, and inoculated the filtrate. The result was positive, the new-born children thus vaccinated developed perfect vaccination pustules.

He was dissuaded from continuing the experiments by some critic who, basing on a well-known citation, asserted that the schizomycetes are able to pass through porous clay. Therefore, the continuation of the experiments was useless for the theoretical investigation.

Last year, however, he became aware of three papers which positively claim that the clay cells retain organized germs. He referred to the article by Chamberland,\* who filtered water in this way and made it free from bacteria,

and two experimental publications by Leube and Sattler. Both succeeded in producing by filtration pure sterilized solutions which remained free from decomposition.

Through these results his former experiments again gained in interest. Although such investigations can hardly decide the question as to the nature of the poison of variola, the method gains in practical value, as we might expect from it that vaccine virus can be simply purified from other carriers of infection, and thus the opponents of vaccination can be deprived of the last justification for their opposition. Further investigations will soon follow.

*Dr. Krukenberg* reported some experiments respecting the transition of solid bodies (sulphate of baryta) into the fetus. The results cannot yet be given.

*Dr. Zweifel* emphasized the fact that the transition of solid bodies had been demonstrated, for instance, the spirillum of remittent fever.

*Dr. Krukenberg* pointed out that the white blood-corpuscles may take up the solid bodies and carry them along. He did not deny the transition of micro-organisms.

*Dr. Zweifel* also exhibited some

#### MEDICATING TUBES,

bent like a sound, by means of which he introduces drugs into the uterus; a small brush inserted into the tube propels the drug.

*Dr. Kuestner* simply attaches rubber to an injection catheter and thus introduces the drug into the uterus.

*Dr. Frommel* (Munich) read a contribution to the

#### HISTOLOGY OF THE OVIDUCTS.

Referring to the findings recently reported by Martin, the reader remarked that Hennig claims the tubal epithelium to be composed of several layers, while Hensen described only one layer. The latter view is correct, but the nuclei are

\*Chamberland, "Sur un filtre donnant de l'eau pur." Comptes rendus, T. 90, p. 247. Ref. in Virchow-Hirsch's Jahrb., 1884, I., p. 496.

not disposed in a row. The cells exhibit remarkable forms, and their nuclei are at different places. On preparations from the tube of a cat, he found a rod-shaped formation; after maceration in 33 per cent. alcohol, this proved to be composed of compressed nucleated cells without protoplasm. The same condition was found in dogs, sheep, and monkeys. The tubal epithelium probably possesses some secretory activity; at the time when the ovum passes through, protoplasm is evacuated into the tube. The mucosa of the tube is arranged in longitudinal folds and makes the impression of villous proliferations. In monkeys and bats, the appearances resemble those of early human embryos. In them we find four main folds, a cross section of which produces a star shape. The human embryo of four months still lacks the muscular structure of the tube. Smaller folds subsequently arise beside the main folds. During pregnancy the folds increase in size; at the same time the lumen of the tube is increased rather than obstructed, owing to the simultaneous growth of the wall. The reader had not found any *glands*. The *vessels* run a longitudinal course and are particularly well developed at the wall of the tube, but show also ample ramification in the villi. In gravidæ the abundance of vessels was striking, not only in the villi, but also in the wall. The paper was illustrated with numerous drawings.

*Dr. Bumm* (Würzburg) read a paper on

THE ETIOLOGY OF PUERPERAL CATARRH OF  
THE BLADDER, BASED ON OBSERVA-  
TIONS OF PUERPERÆ AND EXPERI-  
MENTS ON ANIMALS.

Having had under observation eight cases of puerperal cystitis, the reader had experimented to ascertain the etiology. Catheterization in the puerperium not rarely provokes the catarrh. The urine in these cases is always acid. It invariably contained a diplococcus bearing the greatest resemblance to the gonococcus. The cocci were gathered in colonies which often were arranged

in or around a cell. They differed from gonococci in their staining capacity after Gram's method—they assumed a dark-yellow color—and in their pure culture; they assume the shape of yellow plots, thus showing great similarity to the *Staphylococcus aureus*. This fungus, which according to Doléris is invariably present in the lochia, reaches the bladder with the catheter and increases there. The reader experimented with dogs and kids, and found that, if the bladder was normal and the escape of the urine unhindered, millions of cocci could be introduced into the bladder without any development of colonies supervening in the urine; a short time afterwards the bladder was again cleared. In fact, if all organisms eliminated by the kidneys were to cause cystitis, this affection would be of more frequent occurrence. As the reader's experiments showed, the effect of the fungi on the bladder depends upon whether the mucous membrane is intact or whether it has been placed in an abnormal condition by direct or indirect injuries. In the latter cases a violent purulent catarrh appeared. This seems to indicate that the diplococci found in puerperal cystitis determine the violent purulent character of the inflammation. The stasis of urine in puerperæ, and the contusions of the vesical mucosa which are not rare during labor, favor the nidation of the cocci. It also shows that the latter, like the germs of wound infection, possess only a slight power of invasion, not to be compared with the energy of the organisms of the contagious diseases, *e. g.*, gonorrhœa, anthrax, etc. While the fungi of these diseases take root at all times and under all circumstances, the germs of wound infection require a favorable state of the soil on which they develop. Therapeutically this experience may be utilized in this way, that, aside from keeping aloof the carriers of infection, we may oppose to them a healthy surface.

*Dr. Olshausen*.—Puerperal cystitis is not always of one and the same character. Sometimes it passes away rapidly; at other times the process quickly extends upwards into the renal pelvis, and



even into the kidneys. This condition is accompanied by high fever, often of long duration. After the vesical catarrh is recovered from, the kidney disease remains behind. After several weeks of apparent health, there is a sudden explosion of rigors, pain in the region of the kidneys, etc. After months of intermission another attack may supervene. These prolonged intermissions render the diagnosis very difficult. In other cases, a most offensive odor is present; such cases are very stubborn. It is probable, therefore, that we have to deal with various organisms in vesical catarrh.

*Dr. Michael* (Dresden) had found the same micrococcus as Bumm, in all cases of vesical catarrh with thickened ureter. The urine always had an acid reaction.

*Dr. Hirschberg* inquired whether Olshausen had found the urine clear in the periods of intermission. (*Dr. Olshausen* replied in the affirmative, as regards some of the cases.) The disappearance of the vesical catarrh might also rest on central causes, which he had found to be the case in an attack of hysterical paraplegia.

*Dr. Olshausen* believes that the violent symptoms after prolonged intervals do not indicate that the vesical catarrh persisted or had returned, but merely that there was an exacerbation of the kidney affection.

*Dr. Hirschberg* thought that the differentiation between catarrh of the renal pelvis and that of the bladder was very difficult.

(To be continued.)

### International Congress.

NINTH INTERNATIONAL MEDICAL CONGRESS TO BE HELD  
IN WASHINGTON, D. C.,  
COMMENCING SEPT.  
5TH, 1887.

#### Circular No. 2.

The Ninth International Medical Congress will assemble in the City of Washington, the Capital of the United States, on Monday, September 5, 1887, at 12

o'clock noon, in accordance with the arrangements made at Copenhagen in August, 1884.

*Patrons.*—The President of the United States, the Hon. Grover Cleveland; the Secretary of State, the Hon. Thomas F. Bayard; the President of the Senate of the United States, the Hon. John Sherman; the Speaker of the House of Representatives of the United States, the Hon. John G. Carlisle.

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*Associate Secretaries of the Congress.*—William B. Atkinson, M.D., Philadelphia, Pennsylvania; G. B. Harrison, M.D., Washington, D. C.

The Congress will consist of such members of the Regular Medical Profession as shall have registered and taken out their ticket of admission, and of such other scientific men as the Ex-

ecutive Committee of the Congress shall deem it desirable to admit. The books for the Registration of Members will be open from 9 A. M. to 5 P. M. on Thursday, September 1, 1887, and on each subsequent day during the session, under the charge of the "*Reception Committee*." Any member desiring to anticipate this Registration, can apply by letter to the Secretary-General and forward his dues with his address in full, when a receipt will be returned.

The dues of membership for residents of the United States will be ten dollars (\$10). There will be no dues for members residing in other countries. Each member will be entitled to receive a copy of the "*Transactions*" of the Congress, when published by the Executive Committee.

The General Sessions of the Congress will be devoted to the transaction of business and addresses and communications of general scientific interest, by members appointed by the Executive Committee. A printed "Programme" of the Sessions will be presented to each member on registering. A printed "Order of Business" for each day will also be issued.

The work of the various Sections will be directed by the President of the Section, and the order will be published in a daily Programme for each Section. Questions and topics that have been agreed on for discussion in the Sections shall be introduced by members previously designated by the titular officers of each Section. Members who have been appointed to open discussions shall present to the Secretaries of the Section, in advance, statements of the conclusions which they have formed as a basis for the debate.

Brief abstracts of Papers to be read in the Sections shall be forwarded to the Secretaries of the proper Section on or before April 30, 1887. These abstracts shall be treated as confidential communications, and shall not be published before the meeting of the Congress. Papers relating to topics not included in the list of subjects proposed by the Officers of the Sections, may be accepted after April 30, 1887, and any member wishing



to introduce a topic not on the regular list of subjects for discussion, shall give notice of the same to the Secretary-General at least twenty-one days before the opening of the Congress. The titular officers of each Section shall decide as to the acceptance of such proposed communications, and the time for their presentation. No communications shall be received which has been already published or read before a Society.

The official languages of the Congress shall be English, French and German. Each paper or address shall be printed in the "*Transactions*" in the language in which it was presented. Preliminary abstracts of papers and addresses shall also be printed in the language in which each is to be delivered. All discussions shall be printed in English.

The officers of the Congress and the officers of the Sections, including all Foreign officers, will be nominated to the Congress by the Executive Committee, at the opening of the first Session. A partial list of the officers to be nominated (except the members of Council of the different Sections, the list of whom is at present imperfect), is offered herewith.

The Executive Committee cordially invites members of the regular medical profession, and men eminent in the sciences collateral to medicine, in all countries, to participate, in person or by papers, in the work of this great humanitarian assembly. Communications relating to appointments for papers to be read in the Congress should be addressed to Dr. John B. Hamilton, Secretary-General of the Ninth International Medical Congress, Washington, District of Columbia. All questions or communications connected with the business of the Executive Committee should be addressed to Dr. Henry H. Smith, Chairman of the Executive Committee of the Ninth International Medical Congress, Philadelphia, Pennsylvania. Gentlemen named in any position in the Congress are requested to notify the Chairman of the Executive Committee, as soon as practicable, of any error in the name, title or address in this circular.

Ladies in attendance with members of

the Congress, and those invited by the "Reception Committee," may attend the General Sessions of the Congress when introduced by a member. They will also be invited to attend the Social Receptions. The Executive Committee reserves the right to invite distinguished persons to any or all the meetings of the Congress. The attendance of Medical Students and others interested in the work of the various Sections or in the general addresses delivered in the Congress will be permitted, on the recommendation of the Secretary-General or the officers of a Section, on their taking out from the Registration Committee a general ticket of admission, fee one dollar (\$1); but such persons cannot take part in the proceedings.

All communications and questions relating to the special business of any section, must be addressed to the President or one of the Secretaries of that Section. As many details of the Congress and numerous appointments of officers are yet to be completed, other Circulars will be issued from time to time, as circumstances may demand.

The following is the list, as at present completed :

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By order of the Executive Committee of the Congress.

HENRY H. SMITH, M.D.,

RICHARD J. DUNGLISON, M.D., Secretary.

LIGATURE OF THE EXTERNAL ILIAC ARTERY.—The "Observations on Aneurysm and some Diseases of the Arterial System," by Mr. Geo. Freer (Birmingham, 1807) is one of the classical surgical monographs well deserving study. It embodies the results of experimental research, a digest of Guattani's treatment of aneurysm by compression, and a record of the first case in which the external iliac artery was tied successfully. Freer's assistant was no other than Joseph Hodgson, who beautifully illustrated the memoir, and was soon to become famous as the author of the "Treatise on the Diseases of Arteries and Veins" (1815), which was for many years the standard work on the subject. The external iliac was first tied by Abernethy, and he performed the operation four times, but only his last two patients lived; the first of these was rare, as one of the very few cases in which the procedure has been practised on a woman. Astley Cooper had four successes in six, but Mr. Bryant of Guy's has done the operation six times without a death, and, Mr. T. H. Bartleet has successfully tied the external iliac artery three times at the General Hospital, Birmingham. His patients were males, of the respective ages of thirty-one, thirty-three, and thirty-eight years. In his second case Mr. Bartleet tied the iliac for secondary hæmorrhage after ligature of the common femoral. His third case was operated on with stout catgut, cut short, on June 29th ult. The wound healed almost completely by the first intention, and convalescence has been rapid and uneven. —*Lancet*, August 7.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, AUGUST 28, 1886.

**Editorial.**

CHILDBED FEVER: ITS CAUSES AND PREVENTION: A LIFE'S HISTORY.—Under the above title Dr. Theodore Duka presents in the *Lancet* (July 31, 1886) the history of the researches of Semmelweis which led to the discovery of the causes and prevention of childbed fever, and, in connection with this subject, gives a sketch of the life of Semmelweis. The subject is one of great interest in showing how results are accomplished by patient investigation, and how great principles may develop from the modest and quiet labors of the thoughtful observer and student of nature. The history of Semmelweis's researches constitute an epoch in the progress of science. From his earnest work have sprung the germ theory and the splendid results which we owe to cleanliness and antisepticism. Ignatius Philippus Semmelweis, a Hungarian, was born on July 17, 1818, in the city of Buda. At the age of 19 he abandoned the study of law for that of medicine, and began study in the University of Vienna, from which he graduated as Doctor of Medicine in April, 1844. He enjoyed the friendship of Skoda and Rokitansky by reason of his intelligence and industry as a student, and through their influence began his investigations in Rokitansky's pathological laboratory. He afterwards selected the diseases of women as his speciality, and in 1846 received an appointment as an assistant to Professor Klein in the maternity de-

partment. In this way he became one of the staff in the General Hospital in Vienna. This gigantic institution was opened in 1784. During the first thirty-nine years of its existence there were 71,395 admissions into the maternity, with 897 casualties, giving a death-rate of 1.25. During the service of Prof. Klein alarming outbreaks of puerperal fever occurred with a mortality hardly ever under 5.03, and which sometimes rose as high as 7.45. The most fatal outbreak occurred in October, 1841, and lasted until May, 1843. The death-rate during this period was more than 16 per cent. The clinique No. 1 was under Dr. Klein; No. 2 was under the care of Dr. Bartsch. In both instruction was imparted to students and midwives, and there was no marked difference in the death-rate. The Government afterwards decided that Dr. Klein's clinique should be appropriated to students, and that of Dr. Bartsch to midwives exclusively. A change in the mortality was now apparent. During six years—viz., from 1841 to 1846 inclusive—the mortality in the student's clinique stood at 9.29; in that of the midwives at 3.38. This great fatality in the student's clinique at once attracted attention, and one commission of inquiry followed another, but none could exactly determine the cause of the high rate of mortality. All kinds of explanations were given and recommendations made, which led to no satisfactory results. It remained for Semmelweis to solve the problem which was confusing the minds of many able investigators. He began his researches by a series of self-propounded questions. He observed that atmospheric changes could have no influence, and it became evident that the cause of the mortality must be looked for in local—that is, in endemic-conditions. Turning his attention to the conditions of the two clinics, nothing was discovered in the endemic conditions of No. 1 to differ from No. 2. Overcrowding, the moral influences, excessive death-rate, methods of delivery and other causes which might be capable of determining the greater fatality of the clinique were carefully investigated, with negative



results. In his endeavors to minimize the mortality, Semmelweis had recourse to most extraordinary expedients. It is related of him that patients in clinique No. 1 were kept lying on their left side, simply because such was the practice in clinique No. 2. He even tried to change the details of his treatment. Having observed that Professor Klein did not conduct his examinations with sufficient care and gentleness, he managed by subterfuges to keep the Professor away from serious cases. None of his precautions led to satisfactory results.

In the midst of these inquiries Semmelweis was called upon to vacate the temporary appointment. In March following he again resumed his position as assistant to Professor Klein. About this time the death of his friend, Prof. Kolletschka, occurred from the results of a dissection wound, causing phlebitis, aggravated pleurisy, pericarditis, peritoneal and cerebral complications, with secondary abscesses. The death of this friend made a deep impression on Semmelweis. He says "Kolletschka's fatal symptoms unveiled to my mind an identity with those I had so often noticed on the deathbed of puerperal cases." The cause of his friend's death, he argued, was poisoning by decomposed particles of a dead body; if, therefore, his symptoms were similar to those of the disease which carried off so many women in puerperal condition, then similar causes must here exist as existed in Kolletschka's case. Carrying out this line of argument all the facts dawned upon Semmelweis's mind, and tangible results were soon arrived at. The prevailing tendency of anatomical studies at Vienna impelled the Professors, their assistants, and the students to devote much time to the dissecting rooms. After dissecting, the soiled hands were washed with soap and water, which was insufficient to remove all particles of decomposing matter from the nails and fingers. These were brought in contact with the genital organs of the parlurients during examinations, giving an opportunity for septicæmic poison. The explanation was now perfectly satis-

factory to Semmelweis, and he announced his doctrine of septicæmic poisoning, and at the same time pointed out the prophylactic process by the use of antiseptic applications. Semmelweis at once gave orders that in clinique No. 1 every person, before proceeding to examine any patient, should thoroughly wash his hands with liquid chlorine or chlorinated lime-water. The results of this rule were soon manifest, since in the month of May the percentage of mortality stood at 12.24. By the following November and December the number was reduced to 3.04. Subsequent observations demonstrated to Semmelweis that not only particles from dead bodies alone, but any material in a state of decomposition proceeding from a living organism, even air contaminated from such sources, was capable of generating puerperal fever. Scrupulous attention to the use of disinfectants, combined with separation of patients affected with the disease, brought about the most encouraging results. The death-rate in clinique No. 1 now fell to 1.27 per cent, which was more favorable than the returns from clinique No. 2. To further confirm the correctness of his investigations Semmelweis began to experiment on newly delivered rabbits. The results showed that in these animals symptoms like those in the human subject were produced under exposure to cadaveric infection. The principles thus established were reached through patient research and long processes of reasoning. They were established upon the firm foundation of truth, and time has only added to their stability and value. The name of Semmelweis will go down to posterity along with the great benefactors of our race.

He died early in life, and before the great truths of cleanliness and antisepticism were fully appreciated. All honor to his memory!

THE PROMOTION OF UNION BY FIRST INTENTION.—It is almost always desirable in the case of cutaneous wounds to secure union by first intention, for many reasons. In the first place the process

of repair by primary union is more prompt and satisfactory than that by slow granulation, and, secondly, the cicatrix resulting is not so disfiguring to the exposed surfaces of the body. Wounds about the face, head and hands should therefore always be united by primary union, if possible. It is often surprising to what an extent large cutaneous and muscular wounds can be made to unite by primary intention. The necessary conditions to repair are easily stated, and when carefully enforced will yield exceedingly good results. When we have a wound to deal with, no matter how it is made, it should be cleansed of all dirt or foreign bodies. After the oozing of blood has ceased the raw surfaces should be brought together as carefully and neatly as possible and the coaptation maintained by sutures or adhesive plaster.

In the case of very large wounds two methods may be resorted to. First, a drainage tube of rubber or of threads of cat-gut may be laid along the floor of the wound to secure drainage. When it has accomplished its purpose it may be removed, with the dressing. In the case of cat-gut drainage, they may be allowed to remain and undergo absorption. The cutaneous wound is closed over the drainage tube and primary union will take place. This method of treating amputated stumps and deep cavities remaining after the removal of tumors and the like, has been attended with most satisfactory results. The second method now frequently employed consists in bringing the deep tissues together by buried cat-gut sutures. In this way the wounded surfaces deep down in the tissues are brought into close coaptation and union takes place throughout the entire extent of the wound by primary intention. The cat-gut employed is absorbed without acting as a focus of irritation to the tissues. The cutaneous wound is closed in the same manner as where drainage tubes are used. The results of this method of buried suture are often surprisingly good, so much so indeed as to favor their use in those cases even where deep drainage is employed. In order to secure the very best coaptation of wounded surfaces the operator

should not hesitate to use as many sutures as the exigencies of the case demand. We believe in the importance of placing sutures very close together in plastic surgery where close primary union is desired for more reasons than one. In the first place the lines of union are secured in close apposition by the use of interrupted sutures at short distances and the resulting cicatrix is not disfiguring. In the second place there is less space between the opposing surfaces for the infiltration of blood or serum and other agents which invite pus formation. Good or bad results in plastic surgery depend more upon the care, attention and skill of the operator than upon other conditions, hence those who wish to excel in this line of surgical performance must learn the importance of close attention to details.

After a wound is properly brought together it should be covered with absorbent cotton between layers of antiseptised gauze. Every part of the wound should be included in the cover-dressing. A roller bandage should next be applied to keep the dressings in position and to exercise support to both sides of the wound. If antiseptics and cleanliness have been employed, the dressings should not be removed until consolidation has taken place. It is a great mistake to disturb the dressings and to employ water for bathing the parts. Should pus form pain is apt to be present, and the temperature will be elevated, thus indicating its presence. In the absence of any evidence of pus accumulation allow the wound to remain undisturbed. Complete rest of the wound is the most favorable way in which to secure a successful repair, since disturbances only irritate and separate the surfaces which are being united by the deposit of plastic material. Almost of secondary importance to complete rest is the influence of position. In the case of amputation the limb should be so placed as to allow any fluids that may accumulate to escape from the stump. This may be done by leaving open the dependent angle of the wound for union by granulation. A great deal has been written upon this subject in text-books and monographs,



as an evidence of its great importance. We think the subject may be summed up in the statement that careful attention to minute details and manual skill in their application are at the foundation of all good results in union by first intention.

### Book Reviews.

*Dictionary of Practical Surgery.* By Various British Hospital Surgeons. Edited by CHRISTOPHER HEATH, F.R.C.S., Holme Professor of Clinical Surgery in University College, London, etc. Vol. I and II. Philadelphia: J. B. Lippincott Company, 1886. Pp. 1795. Price \$7.50.

The two volumes before us, embraced under one binding, present a most useful and comprehensive work to the busy practitioner. The general plan of the work is to treat the various surgical diseases and injuries in an alphabetical order. Each disease is described under the following heads: 1. Cause; 2. Pathology; 3. Symptoms and Diagnosis; 4. Treatment; 5. Prognosis. The various articles are written by a large number of well-known British Surgeons connected with the Staffs of the various Metropolitan Hospitals. The work is a compendium of the practice of British Surgery of the present day. It will be found exceedingly useful as a handy work of reference to the busy practitioner.

*A System of Practical Medicine.*—By American Authors. Edited by WILLIAM PEPPER, M.D., LL.D., Assisted by LOUIS STARR, M.D. Volumes IV and V. Philadelphia: Lea Brothers Co. 1886.

Volumes IV and V of this valuable work are devoted respectively to Diseases of the Genito-Urinary and Cutaneous Systems, Medical Ophthalmology and Otolology, and to Diseases of the Nervous System. The two volumes before us are quite up to the standard of those previously noticed. Many of the papers are to be commended for their clear and comprehensive treatment of the subject-matter under consideration.

The fifth volume closes the series, which taken as a whole, is one of the most useful and valuable treatises upon practical medicine which has ever been given to the profession. The first volume of the series was issued in January, 1885; the second in May, 1885; the third in September, 1885; the fourth in February, 1886; and the fifth and last volume in June, 1886.

Considering the character and scope of the work, and the large and complicated literary labor involved in its preparation, such punctuality reflects credit on the zeal of the contributors and the energy and resources of the publishers. An idea may be had of the extent of the work by the following statement: The number of articles is 185, written by 99 authors, covering, with indices, about 5,600 pages.

Throughout the entire work the original purpose has been kept in view of making it of practical value to the general practitioner. In looking over the large number of articles, as we might expect, a few fail to come up to the standard of excellence demanded of such a work, but these few deficiencies are more than equalized by the general excellence of the majority of the contributions. Not a few of the articles have the highest literary and scientific worth and are models of their kind. The work is exclusively the labor of American practitioners, and, as a contribution from the American school to the department of practical medicine, will rank side by side with the many far-famed works of the Transatlantic schools. It is a work which should occupy a place in every physician's library.

### Miscellany.

A NEW PROCEDURE FOR PERMANENT DILATATION OF THE UTERUS.—This process, applied by Professor Vulliet for the past three months at the Maternity Hospital, Geneva, enables one to see the whole interior of the uterus admirably.

M. Vulliet has been able to study the condition of the uterine cavity, even during menstruation, and to see in what

manner the hemorrhage takes place; to take photographs of the uterine cavity, and interesting casts, of which he has shown several specimens before the society.

In proceeding to the dilatation of the uterus, it is first necessary to place the patient in the genu-pectoral position, with the hips well raised, the perineum and posterior vaginal wall lifted as much as possible by means of a speculum blade on the dual aspect. Then the dilatation of the uterus is begun by first introducing either urethral sounds or bougies of various sizes, according to the narrowness of the uterine canal, and the resistance of the organ. The introduction of these instruments is succeeded by small tampons of iodoform cotton wool, gradually increasing the number, usually leaving them *in situ* for 48 hours.

Sometimes for the purpose of making dilatation more speedy and regular, M. Vulliet uses laminaria tents; these he leaves not longer than 24 hours, and immediately applies an iodoform tampon to destroy the germs which the laminaria may have introduced. Thus proceeding in a regular manner, we succeed, at the end of a period varying from nine or ten days to five weeks, according to the patient, in obtaining complete dilatation of the uterus, which allows us to study perfectly the whole inner surface of the uterus.

In the thirteen cases in which M. Vulliet has applied his method, he has always observed that the tampons were borne without inconvenience, with the exception of sometimes colic, very slight, which occurred during the first few days. If the uterus be permitted to return to its normal state, and we wish to repeat the dilatation, we succeed much more rapidly than in the first instance.

M. Vulliet has employed his method especially in women affected with uterine cancer, and sometimes in cases of fibro-myoma. In cases of uterine cancer, once the uterus is completely dilated, we can then apply various substances over the whole surface of the cancer, or treat the neoplasm in whatever way may seem most appropriate.

According to M. Vulliet, the presence

of tampons would produce at the same time a very favorable hyperplastic action on the uterine tissues, which assists in combating the neoplasm. In several cases the author was able, thanks to the dilatation, to apply very energetic local treatment, and obtained some remarkable results, at least as far as one could judge after three or four months.

The condition of the patient was found to improve in the sense that the hemorrhages, the foetal discharges, and offensive odor were suppressed—results not to be despised, for they restore these unfortunate women to social life.

Permanent dilatation is an acquisition for gynecology; it will very much facilitate the local treatment of numerous uterine affections, and will probably in the future be more and more frequently practiced.—*British Gynaecological Jl.*, May, 1886.

#### GASEOUS MEDICATION PER RECTUM.—

The ingestion of gaseous medicines by the lower bowel was the subject of a recent communication by M. L. Bergeon to the Paris Academy of Sciences (*Comptes Rendus*, July 12th). His research has extended to a variety of diseases, but for the present he only records his experience in the treatment of pulmonary phthisis. After having tried a variety of balsamic substances of parasiticide or antiseptic repute, M. Bergeon gave the preference to sulphurous mineral waters (Eaux Bonnes Challes, &c.). A current of from four to five litres of carbonic acid gas traversing from 250 to 500 grammes of the sulphurous mineral water was introduced per rectum twice in the twenty-four hours. After a few days' use, cough was notably diminished and almost suppressed, the expectoration greatly modified in quality and quantity, the sweating stopped, and the general state improved; and that not only in incipient, but also in confirmed phthisis. Daily auscultation established the disappearance of moist râles.—*Lancet*, Aug., 7, 1886.

RE-INJECTION OF BLOOD DURING AMPUTATION AT THE HIP-JOINT WITH RAPID RECOVERY.—By A. G. Miller, M.D.,



Edinburgh. In a case of strumous disease affecting both hips, the left knee and the left elbow, with a large abscess connected with the left hip, the patient being in very feeble condition, amputation at the latter joint became necessary. The limb having been exsanguinated to the middle of the thigh, and a powerful elastic tourniquet applied at the groin, a rapid circular cut was made right down to the bone in the upper part of the thigh, the femur sawn through, the femoral artery and some smaller vessels tied, and the tourniquet removed; some hæmorrhage still occurring from a few small vessels, they were also ligatured. All the blood which escaped, both from the femoral artery and the smaller vessels, amounting to eleven ounces, was caught in a vessel containing a solution of phosphate of soda and re-injected into the deep femoral vein. By an incision on the outer side of the thigh the head of the femur was then dissected out. The wound was dressed antiseptically. The patient suffered no shock whatever, nor depression of temperature after the operation. For the first few days, he was flushed and had a fuller pulse than before the operation, but he had no rise of temperature. The weakness and the anæmia of the patient, together with the increased vascularity of the parts due to the disease, rendered it very likely that he would not have survived the operation, had not the greater part of the blood lost been re-injected—the fact being that from the exsanguination of the leg, together with the re-infusion, there was probably an ultimate gain of blood after the operation.—*Edinburgh Med. Jour.*, February, 1886.—*Annals of Surgery*, 1886.

#### THERAPEUTICAL NOTES.

(From the Journal of Cutaneous and Venereal Diseases.)

*Glycerole for Cutaneous Pruritus.*—

R. Acidi carbolic, . . . gtts. xv.  
Sodii biberatis, . . . 3 grains.  
Glycerinæ, . . . 30 grams.

M. Apply with a brush over the pruriginous surfaces.—*Le Concours Médical*, No. 18, 1886.

*Cocaine in Herpes Zoster.*—In a case of herpes zoster, occurring in a child of 7 years, in which all ordinary remedies failed to give relief, Weissenberg applied a five-per-cent solution of cocaine every two hours over the seat of the eruption. That night the child slept quietly, without being awakened every five minutes, as during the previous night, by the burning pain and itching. The following day the pain had ceased, but there remained an itching, which was attributed to the astringent action of the cocaine, which found in the ruptured bullæ an easy mode of penetration to the Malpighian layer. The itching soon disappeared, and at the end of twelve days no trace of the eruption remained. The cocaine, in addition to its anæsthetic properties, was thought to have hastened cicatrization.—*Allg. Med. Central-Zeitung*.

*Solution for Vulva Syphilides.*—

Hydrate of chloral, . . . 5 grains.  
Tinct. eucalypti, . . . 10 grains.  
Aq. destillat, . . . 100 grains.

M. f. sol. for the dressing of mucous patches and ulcerous syphilides.—*Jour. de Méd. de Paris*, June 13, 1886.

*Cocaine and Boric Acid in Gonorrhœa.*—M. Bedoin employs bougies containing ten to twenty centigrams of cocaine in the early stage of gonorrhœa. They were found to have an excellent effect in calming erections. At a later stage he employs bougies containing twenty to twenty-five centigrams of boric acid. The duration of the treatment was from ten to twenty-three days.—*Le Progrès Médical*, June 12, 1886.

*Application for Warts.*—The following formula, a modification of that recommended by M. Vigier for corns, is largely used by Vidal:

R. Acid. salicylici, . . . 1 gram.  
Alcohol, 90°, . . . 1 gram.  
Ether, . . . 2½ grams.  
Collodion, . . . 5 grams.

M. The solution should be painted over the affected surface each day.—*Jour. de Méd. et de Chirurg.*, June, 1886.

### Medical Items.

Prof. Wm. D. Booker, M.D., of Baltimore, has been recently appointed one of the Vice-Presidents of the Section of Diseases of Children of the Ninth International Medical Congress.

HONORS TO MEDICAL MEN IN ENGLAND.—The *Lancet* announces the conferring of knighthood on Mr. John Tomes, Dr. Douglass Mac-lagan, Dr. B. W. Foster, Surgeon-General Longmore, Dr. Edward Sieveking and Mr. Wm. Stokes.

Prof. Breisky, the celebrated obstetrician and gynecologist of Prague, has been appointed by the Emperor of Austria to succeed Prof. Spaeth as professor of obstetrics and gynecology in the second clinic at Vienna.

Dr. Mary A. Dixon Jones, of Brooklyn, reports nine consecutive cases of removal of the uterine appendages with recovery in the *N. Y. Med. Record* of August 21st, and writes a good article, to boot. Who says our professional sisters are not progressive?

Dr. Skene Keith, not yet 30 years of age, has already performed 81 laparotomies with but 4 deaths, and he is also putting into practice, at every opportunity, the ideas he received in plastic work and treatment during his recent visit to this country and to the Woman's Hospital.—*N. Y. Med. Journ.*, Aug. 21, 1886.

The second official circular of the Ninth International Medical Congress is herewith published. It is with great regret that we note the absence of the names of so many of the master minds of our profession. It is true that some of the most distinguished of our brethren still occupy prominent positions in the Congress, but many of the Sections are composed of men who, whilst occupying respectable positions in their respective localities, are not sufficiently well-known to secure the confidence of the mass of the profession at home, or attract the best talent from abroad.

Sayre's Orthopedic Surgery has been translated into German by Dr. Dumont, and is receiving a severe drubbing at the hands of the critics. Prof. König says it must have required much courage to present the translation of such a work to the German reader, and that a poor service has been rendered American surgery by this translation.—*Centbl. fr. Chirg.*, 1886, No. 21. As the second edition of the work was written nearly four years ago, Dr. Sayre is somewhat excusable for being rather behind the times in regard to the present status of the pathology of joint affections.

A NEW MEDICAL COLLEGE IN ST. LOUIS.—A new medical school has been organized in St. Louis under the name of Beaumont Hospital Medical College. The faculty have purchased a suitable building, (which, from the wood cut, seems to be a retired church) and the first regular session will begin on October 4th. The

corps numbers 19 professors and a demonstrator of anatomy. The names of the new professors are, with few exceptions, unknown in this part of the country. We do not see that the new college promises to be either better or worse than the five or six others which are already in existence in the same city.

A COUNTRY PRACTITIONER'S PESSARIES.—Now we may have a prolapsus to relieve, or an anteversion or retroversion. We must relieve it in some way. How will we go about it? We will send to the drug store (if there is any) and order one made; if there is no drug store, we will have to make one ourselves. We would like to see our "city cousins" make one!). We possess ourselves of some powdered elm-bark, gum acacia and some disinfectant, iodoform, for instance. After triturating thoroughly these ingredients, and perhaps medicating them some more, we moisten enough to make a thick dough and mould into the desired shape, then dry.—*St. Louis Courier of Medicine*.

ANOTHER LAPAROTOMY FOR GUN-SHOT WOUND OF THE INTESTINES BY DR. BULL.—Dr. W. T. Bull, of N. Y., whose successful laparotomy for intestinal wounds about 18 months ago, has done so much to establish the propriety of this operation, has again successfully repeated the operation for gun-shot wound of the intestine. A man was shot in the abdomen below and to the left of the navel, and two hours subsequently, when there were no symptoms of intra-abdominal injury, the belly was opened, much blood was found in the cavity, two perforations of small intestine, one of sigmoid flexure and one of the mesocolon, from which venous hemorrhage had taken place. Case was doing well on fifth day, pulse between 90 and 110, temp. varying from 99° to 100°.—*N. Y. Med. Record*, August 21, 1886.

THE AMERICAN DOCTOR.—I have spoken to little purpose if I have failed to show you that there is a great deal of human nature in American physicians, and it is a kind of human nature with which you are tolerably familiar. Our ancestors were restless, fighters, freebooters, and from these ancestors we have the common inheritance of energy; of what we call "firmness," and our opponents "unreasonable, pig-headed stubbornness; of liking to manage our own affairs, and, at the same time, to exercise a little judicious supervision over those of our neighbors; of hatred of humbug and lying; and in spite of our discontent, of a firm belief that our wives and children, habits and houses, mode of business and of treating disease are, on the whole, better than those of any other people under the sun. Privately, and between ourselves, we grumble and declare that the country and the profession are going to the dogs,—nay, we must do so, or we would not be of true English blood, but there is no need for me to tell you that these are only "growing pains," and not symptoms of progressive ataxy.—*Billings Address*.



## Original Articles.

## A CASE OF MEMBRANOUS COLITIS.

BY RANDOLPH WINSLOW, M.A., M.D.,

Professor of Surgery in the Woman's Medical College of Baltimore, Lecturer on Clinical Surgery in the University of Maryland.

Dr. W. A. Edwards contributes an interesting article to the *Medical News* of August 17, upon Intestinal Casts, which brings to my mind a case of perityphlitis or pericolitis, in which the discharge of membranes was a prominent feature.

I. R. W., female, 18 years of age, was taken sick suddenly in the night of November 6, 1879. She had gone to bed well, and awoke in the night, with nausea, which continued through the night, and her bowels were moved once. She was unable to sleep during the balance of the night, and in the morning was weak and felt badly but got up and remained out of bed most of the day. Vomiting continued and pain developed on the right side of the abdomen. The catamenia which had never been very regular, or very free, appeared the next day after this seizure, without, however, relieving the pain, indeed the distress increased, and the sensation was experienced, as if she was tearing open when she breathed. The pain was chiefly referred to the ascending colon. Fever was developed and on the evening of November 8, the temperature reached  $103^{\circ}$  and the pulse 120. The tongue became furred, the abdomen tympanitic and pain and tenderness marked over the whole abdomen. She became unable to move herself and lay in one position upon the back with one limb flexed upon the abdomen, the other extended. By this time nausea and vomiting had pretty much subsided, and the bowels required enemata to produce an action, the appetite was lost. On November 9, the temperature was  $101\frac{3}{5}$ , pulse 106, there was no alteration in the extent of tenderness; quinine and morphia 10 grs. of former and  $\frac{1}{4}$  gr. of the latter were given sufficiently often to keep the tem-

perature reduced. Ten leeches were applied to the abdomen, and subsequently fomentations; the leech bites bled freely, which was controlled by the topical application of ol terebinthinæ, after the failure of several other expedients. Whenever the temperature rose, quinia sulph., grs. 10, sufficed to reduce it in a short time, and by its administration, it was kept about 100 in the morning and 101 in the evening, with a pulse rate about 90. About one week from the onset of the attack the peritonitis subsided, and the pain nearly disappeared, but a circumscribed swelling was discovered about the caput coli, which was painful upon pressure. This increased in size, and became well defined, and reached as high as the umbilicus, and occupied the course of the ascending colon, but also dipped down into the pelvis. Purgatives caused free catharsis but did not diminish the size of the tumor, but did relieve the tympanites. As there was gastric irritability, bismuth was administered. A blister 6x8 was applied over the tumor and subsequently poultices. Not much medicine was given, except an occasional dose of quinine and morphia, and sometimes a laxative or enema. For a while it was necessary to draw the urine with the catheter. Her condition continued about the same until November 18, when her evening temperature rose to 102, pulse 105, without any especial exciting cause as far as could be seen. She spent a very bad night, but was cheerful the next morning. Cannabis indica in  $\frac{1}{4}$  gr. doses was ordered. About 3 P.M., on the 19th an enema brought a large piece of membrane from the bowel. This membrane was submitted to microscopic examination, and seemed to be made up of a basement membrane holding a tessellated collection of flat cells, which were not so large as the ordinary squamous epithelial cells, but which certainly did not resemble the columnar intestinal epithelium, large aggregations of what appeared to be fibrine were also adherent to the membrane. If this was a desquamation of the intestinal mucous membrane, it was very much altered from normal.

November 19, evening temperature  $102\frac{3}{5}$ , pulse 104. Ordered blue mass gr. i, and morph. sulph. gr.  $\frac{1}{8}$  every three hours.

20th, A. M., temperature  $99\frac{3}{5}$ , pulse 92, has headache, has taken more nourishment than usual. P. M. temperature 100, pulse 82.

21st. Evening temperature rose to  $102\frac{3}{5}$ , and it was subsequently noticed that elevation of temperature generally coincided with the extrusion of membranes.

22nd. Tumor extends to left of umbilicus, and from thence into the pelvis, it feels more elastic as if some pus might have formed. The passage of membranes continued, sometimes daily, at other times paroxysmally.

On the 25th a diarrhœa set in, and with it a marked subsidence of the tumor. No abscess was detected externally and if pus formed it must have escaped into the bowels, or the swelling may have been largely fecal which passed off with diarrhœa. At any rate convalescence dated from the profuse diarrhœa, though the membranes continued to be passed for at least a year. At one time she passed blood per anum. But little remains to be added to the clinical history of this case. The young lady recovered, but has never regained her previous health, and is evidently suffering from a constriction of the intestine or a paralysis, as she is never able to have a passage without an enema, she was formerly an active and strong girl, now a slight exertion breaks her down. In regard to the causation of this attack it is probable that it originated from the injudicious drinking of a large quantity of bad vinegar. Interesting in this connection is the fact that the father of this patient had a severe typhlitis in 1872, which he ascribed to taking a glass of soda water from the fountain of one of our druggists, after it had been standing all night.

As is remarked by Dr. Edwards in the article alluded to, these cases of discharge of membranes and casts from the bowels are of a sufficient rarity to attract notice, and their study has been somewhat hindered by a multiplicity of technical terms. Da Costa in October, 1871, published

a valuable paper upon Membranous Enteritis, by which term, however, he designated a chronic or subacute affection of the bowels, with the discharge of membranes, in which the health of the patient suffered more or less, but without many acute or dangerous symptoms. The case reported by Edwards is similar in character to those of DaCosta, and concerns a mulatto woman who for eighteen months has passed intestinal casts, her general health remaining unaffected. These cases seem to belong to a distinct primary affection of the bowels, whilst the case just recorded was consecutive to a circumscribed peritonitis of the cæcum and ascending colon, at least the acute inflammatory process of the peritoneal surfaces had been sometime in progress before the membranes were discovered. Dr. Bristowe in Reynolds' System of Medicine, divides enteritis into catarrhal and croupous. He designates as "croupous enteritis those cases which are characterized by membranous deposits consisting of corpuscular elements cemented together by coagulable exudation," and he thinks "it indicates greater intensity of inflammation than mere catarrhal inflammation. There is generally much greater congestion and thickening of the mucous membrane, and not unfrequently hæmorrhage, suppuration and gangrene. It is often met with in the large intestine in scattered patches, but in some it forms uniform patches of considerable extent." Neither time nor opportunity permits me to go with any degree of fulness into the literature of this subject, but the case possessed very great interest to me at the time it was under observation, and I thought it might be of some interest to the readers of this JOURNAL. The record is taken from notes made at the time.

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AN ARTIFICIAL HEEL BY GRAFTING.—At a meeting of the Academy, M. Berger presented a patient in whom he was able to make an artificial heel by means of a large lump taken from the opposite leg. The graft succeeded completely, and the heel is now perfectly restored, but sensation has not yet appeared.—*Med. Record.*



DIPHTHERIA. — WHOOPING  
COUGH.—RESORCINE.

BY JOHN MORRIS, M.D., OF BALTIMORE.

About six weeks ago I was called to see a little boy who was suffering from a sharp attack of whooping-cough. The disease had progressed to the third week. He had high fever, which I first thought might be due to an intra-current bronchial trouble. On examination of the premises, however, I came to the conclusion that the fever was due to malaria or some zymotic cause. The house was built directly on the ground, and the walls were damp and covered with mould. I have frequently observed cases of diphtheria in which there was no history of contagion, but in which I believed I could trace the origin of the disease to conditions such as I observed in this house. Dampness I have always thought a most important factor in outbreaks of diphtheria. On my second visit to my little patient I discovered the characteristic membrane of diphtheria covering both tonsils which extended afterward to the pharynx. The boy suffered from fever for three or four days, but made a good recovery. The whooping-cough, strange to say, ceased entirely from the time of the appearance of the diphtheria and has not returned since. This is not a mere coincidence, for the child's sister who was isolated and did not contract diphtheria is still suffering severely from pertussis. My theory as to the cause of the disappearance of the whooping-cough, is that the micrococci of this disease which have their harbor in the lining membrane of the pharynx and air passages were destroyed by a more vigorous parasite, and this would tend to strengthen the views of Professor Moncorvo, who strongly urges the use of resorcine as a local application to the surfaces involved. Professor Moncorvo believes, 1. "That whooping-cough is to be classed among the diseases which are caused by the irritation excited by the presence of parasites. 2. That is it due to the presence of micrococci, which proliferate in large numbers upon the lining mem-

brane of the larynx and pharynx, and which infiltrate the epithelial cells, which seem to be the preferential seat of their growth and increase. 3. That resorcine in a solution of the strength of 1 to 2 per cent. applied directly to the mucous surfaces concerned, has been found in all cases in which it has been employed and the results watched to rapidly reduce the number of chinks, to reduce their intensity, and finally to lead to the cure of the disease." The application is made by means of a brush or swab and the interior of the larynx can be reached by a spray.

I have no doubt myself as to whooping-cough being a parasitic disease and that it will prove eventually a curable one. Resorcine may not be the best agent, but some remedy will be discovered that will prove entirely efficacious. Dr. Barlow who accepts Professor Moncorvo's views, thinks that orcine, the congener of resorcine may be a better application inasmuch as it is milder and less irritating.

The whole subject is worthy of study and investigation and all clinical observations that throw any light on the matter should be received with attention and interest. It is with this view that I write this very brief paper. Perhaps the "Wilson Sanitarium" may afford a field in the future for the discovery of the origin of many infantile diseases the exact nature of which we are ignorant.

**Abstracts and Extracts.**

THERAPEUTICS OF SYPHILIS.—At the last "Kongress für innere Medicin," held at Wiesbaden, considerable attention was given to the above subject, in which Professor Kaposi, of Vienna, led in the discussion. He called attention to the fact that to-day, as four hundred years ago, mercury constitutes the standard treatment, and only a single addition has since been made to the therapeutics of syphilis. He did not hesitate to affirm, however, that not only was syphilis a curable disease, but that of the different infections, constitutional diseases, it was the one which, with proper treatment,

was most easy of being thoroughly eradicated from the system. He propounded three questions, and proceeded to discuss each in its turn. His first question was:

*Is there any positive method whereby the primary effects of syphilis may be treated and an immediate eradication of the disease thus produced?*

If the initial step of the disease be viewed in its proper light, to wit: that the specific virus remains for a certain (although indefinite) time in the primary lesion, and is drawn up from here into the lymphatics and blood-vessels, three possible means present themselves of effecting the desired result. They are: I. The destruction of the virus at the point of infection in and with the primary lesion, by means of cauterization or excision. The objections to this are that we are absolutely without any data as to the time that the syphilitic virus may remain in a lesion before it is absorbed, and that even favorable results are not of statistical value because every sclerosis is not followed by the disease. Neither the presence nor the absence of the glandular enlargements gives us definite data for knowing whether a primary lesion be syphilitic or not. If the relation of Lustgarten's bacilli to syphilis were fully demonstrated, their presence would doubtless constitute an effective criterion for the diagnosis of the primary lesions. Excision is practicable when coupled with certain advantages, topographical circumstances, as, for instance, if, on the margin of the prepuce, but almost wholly impracticable if on the glans or in the sulcus. Emplastr. hydrarg. is effective in the local treatment of the primary lesion. II. the disturbance or destruction of those vessels which constitute the immediate path of absorption of the virus. Prof. Kaposi thinks that whoever first made this suggestion should have accompanied it with more specific instructions. Which lymphatic vessel shall be severed? The whole penis lies imbedded in a web of lymphatics, and, without more exact knowledge, how can the prevention to be incurred by the very sweeping operation necessary under the circumstances be kept down to its traditional proportional

ounce? III. Preventive measures. Although it is theoretically wrong to proceed with the eradication of a disease by first letting it fully develop, still he has observed that an early treatment does not prevent the subsequent appearance of tertiary symptoms, which, under such circumstances, often appear, and in severe forms. He urgently advises not to be too hasty with the mercurial treatment.

The second question was: .

*What are the respective advantages of the different remedies used in the treatment of syphilis?*

Hospital statistics are of no avail, because the patients usually disappear as soon as the lesions have been removed; and since private statistics are not to be had, we are referred to individual cases, from which it is impossible to form comparative judgement. Mercury is applied endermically, hypodermically, and through the organs of digestion. Of endermic means, the inunction method with ung. hydrarg. is the most important. The plain ointment is the most reliable and efficacious means of treating early syphilis. Lanolin ointments and mercurial soaps (the latter of which is quite effective) are not as desirable as the first method. Intestinal affections and pyalism very infrequently accompany the application of the blue ointment, and by means of it is obtained a happy medium between absorption and elimination. Hg. plasters and Unna's Hg. plaster-mulls are generally of little use, but may be applied with advantage in the local treatment of irritative and later syphilitic sores. Mercurial baths are very efficacious in the treatment of newly-born infants and adults suffering from ulcerous eruptions.

The hypodermic method is direct, exact, and convenient, and beside the original sublimate solution of Lewin a number of other preparations have been experimented with. The following three groups of Hg. remedies have been arranged by Bockhart with reference to their permanency:

1. Most permanent:

- |                                      |                 |
|--------------------------------------|-----------------|
| a. Inunction method (ung. hydrarg.). |                 |
| b. Calomel injection                 | } subcutaneous. |
| c. Lewin's sublimate solution        |                 |



2. Moderately permanent :

- |                                 |                 |
|---------------------------------|-----------------|
| a. Sublimate-chloride of sodium | } subcutaneous. |
| b. Hg. albuminate and peptonate |                 |
| c. Blood-serum mercury          |                 |

3. Less permanent :

- |                   |                 |
|-------------------|-----------------|
| a. Hg. bichyanide | } subcutaneous. |
| b. Hg. glycolcoll |                 |
| c. Hg. formamide  |                 |

The formamide is the least painful.

Internally, the customary Hg. preparations (sublimate, calomel, and hydroxyd. tann.) act usually more slowly than the others; still, they are quite effective, and especially the last causes but slight discomfort to the stomach. In France, proto- and deuto-iodide of mercury find great favor as internal remedies.

Mercury is best adapted for all forms of affections of the skin, both in the early and late periods, and in acute conditions of the bones, the parenchymatous organs, and of the cerebro-spinal system, whereas the latter nervous affections of the joints and cephalagia syphilitica yield decidedly more quickly to iodine treatment. The more promptly and actively treatment is begun in the first acute stage of the disease the less is the probability of a relapse. Therefore, inunctions, or, if these are not possible, injections should be energetically begun at the proper time, and the most permanent remedies should be selected. All slow-working remedies cause only a prolongation if applied in the acute stage. Only in case of later affections, such as localized papulous formations, may they be applied, but in affections of a dangerous nature, such as iritis, ulcerative nasal or throat affections, or those of the brain or spinal column it is essential to use the most energetic means, and especially the inunction method with ung. hydrarg.

Iodine is especially good in cases of bone and joint affections and also for nocturnal pains in the bones and in the head. It can also be prescribed for syphilitic symptoms during the later periods, but should *never* be used alone in the beginning of the disease, owing to the protracted course of eruption which follow it. That iodine can be used as a corrective against the misuse of mercury is a total misconception and utterly without foundation.

Zittmann's decoction of herbs is a very potent measure for later stages, and

especially for ulcerative formations of the skin and throat. Prof. Kaposi often combines the use of this decoction with inunctions, and observes that the presence of Hg. does not affect its activity. Sulphur-baths, sea-baths, and hydro-pathic treatment have not the slightest specific effect upon the disease.

*How long should treatment be continued?*

Concerning the third question, as to the length of time and the repetition of treatment, Prof. Kaposi advised a long and careful course for from three to six months, and to repeat the treatment only when relapses occur, and not in order to prevent them. He did not object, however, to a light course of treatment for safety's sake.

Prof. Neisser, of Breslau, did not agree with Prof. Kaposi in his views with reference to an advisable delay in the treatment. He believed in cauterization with concentrated carbolic acid, or, if possible, excision. He believed it advisable to use every opportunity for the prevention of the outbreak of syphilis, and destruction of its virus. He agreed generally with Fournier in his views, and in the treatment preferred, as he said, to recognize the individual, and fashion his treatment thereafter than to recommend any single system for all cases.

Prof. von Ziemssen, of Munich, recommended especially hypodermic injections of bichyanide of mercury, and after a lengthy discussion Prof. Kaposi closed by expressing the hope that physicians generally might add statistics from their private practice, so that more extensive data may be available.—*Deutsche Med. Wochenschrift*.—*Jour. of Cut. and Ven. Dis.* Aug. 1886.

CRITICISMS ON FAMILIAR PRESCRIPTIONS.—Dr. James A. Kyner, Demonstrator of Chemistry, Pennsylvania College Dental Surgery says in the *Poly-clinic*, August, 1886: I desire to call attention to some incompatible prescriptions that have come to my notice during the past few months, and suggest methods of modifying some of them, so as to render them compatible without setting aside the therapeutic effect intended.

Incompatible prescriptions may be divided into three classes—pharmaceutical, chemical, and physiological.

Pharmaceutical incompatibility nearly always depends upon the disproportion between the alcohol and water in the preparations joined in the prescription; in such a mixture as—

Tinct. nucis vom.,  
Ext. ergotæ flu., *āā* f3j,

alcohol is in excess; the latter being made with dilute alcohol, and containing substances not soluble in strong alcohol. These are, therefore, precipitated, when added to tincture of nux vomica, which contains eight parts of alcohol to one part of water.

The precipitate clings to the bottle, causing considerable loss of the medicinal constituents of the ergot. After several experiments, I found the following to give a clear mixture:

Tinct. nucis vom.,  
Ext. ergotæ flu., *āā* f3vij  
Aquaë, f3ij.

Another incompatibility of the same order is

Ext. ergotæ flu., f3 iiss  
Tinct. ferri chlor., f3 ss

The precipitate in this case may be avoided by diluting the tincture of iron with an equal volume of water.

Another form is

Resinæ podophylli, gr. j  
Syr. rhei aromat., f3ij.

The resin being insoluble in the syrup, no matter how intimately they are mixed, it will separate in time and adhere to the bottle. The addition of a small quantity of aromatic spirits of ammonia, which mixes very well with the syrup, will dissolve the resin and avoid the objections.

It is a common thing to receive a prescription for compound tincture of cinchona, combined with aqueous fluids; a precipitate being almost invariably the result. Very few tinctures and fluid extracts bear dilution with water. When dilution is necessary, simple elixir will generally do better.

Chemical incompatibilities are de-

pendent on the laws of chemistry, and the nature of the substances involved is materially changed. The only remedy is to avoid the use of the incompatible substances in the same mixture. I have frequently received this prescription:

Zinci sulph., gr. xx  
Pot. sulph., gr. xxx  
Aquaë, f3iv.

The zinc sulphate and potassium sulphide react to form insoluble zinc sulphide and potassium sulphate.

Also

Quin. sulph., gr. xxx  
Ac. sulph. dil., q.s.  
Pot. iodidi, 3 ij  
Aquaë, q.s. f3 iij.

Potassium iodide produces precipitates with most alkaloids, and in this case gives such a bulky yellow precipitate with the quinine as to render the mixture unfit for use.

Another:

Hydrarg. bichlor., gr. j  
Sodii biboratis, gr. xx  
Glycerinæ, f3 iv  
Inf. picis liq., q.s. f3iv.

By action of the borax an insoluble mercury salt is formed, and as the mixture is intended for a spray, no effect can be expected from the mercury. Another similar to the above, with zinc sulphate instead of mercuric chloride, to be used also as a spray, is rendered inactive by the zinc forming an insoluble salt with the borax.

In the following,

Magnesii sulph., 3 ss  
Sodii phosphatis, 3 ss  
Sodii chloridi, gr. xx  
Ferri sulph., gr. x  
Inf. quassiaë, f3 iv.

insoluble magnesium phosphate is formed, making a very unsightly mixture.

So also

Morph. sulph., gr. j  
Syr. scillæ co., f3 j  
Sodii bicarb., 3 j  
Aquaë, f3 iij



The alkaline carbonate causes the morphia to precipitate, and after standing several days, all can be collected on a filter; the filter giving no reaction for morphia.

Another on the same principle is

Morph. sulph.,	gr. vj
Sodii biboratis,	3 iv
Aquæ camphoræ,	f 3 vj.

Here the borax acts the same as the carbonate in the previous case.

Prescriptions similar to the following are common, owing to the fact that licorice is an excellent vehicle for quinine.

Quininæ sulph.,	gr. xxx
Acid. sulph. dil.,	q.s.
Ext. glycyrrhiz. flu.,	
Syrupi,	
Aquæ	āā f 3 j.

Glycyrrhizin, the sweet principle of licorice, is a compound of glycyrrhizic acid and ammonium, and in the presence of acids is decomposed; glycyrrhizic acid being set free. This is a very peculiar insoluble gelatinous substance, which carries the quinine down with it, and forms a semi-solid mass in the bottom of the vessel. The ammonia aids in the precipitation by neutralizing some of the acid which holds the quinine in solution.

It is hardly within my province to discuss physiological incompatibility, but the prescribing of pepsin combined with sodium bicarbonate, is so frequently done, and is so gross an error, that it deserves mention. This practice has become so common that a certain hospital in this city has the following formula in its pharmacopœa:

Pulvis pepsinæ et sodæ,	
Pepsinæ sacchar.,	gr. ij
Sodii bicarb.,	gr. j.
M. ft. chart. No. 1.	

THE MICROBES OF PNEUMONIA.—The subject of acute pneumonia is one of those which of late has excited a considerable amount of attention, and yet, common as the disease is, it is one which is surrounded by many unsolved problems. Professor Weichselbaum has re-

cently contributed to the Vienna Medical Society a paper in which, after stating the prevalent opinions upon the nature of the affection, and dwelling especially upon the different opinions held by Friedländer on the one hand and Fränkel on the other as to the precise characters and properties of the supposed bacterial agent, he relates his own experiences. He points out that clinicians are divided into two camps upon the etiological question, some regarding pneumonia as solely an infective disorder, others considering that the infective forms are different from those caused by exposure to cold. Weichselbaum, distinguishing between primary and secondary forms, divides them into (1) lobar; (2) disseminated; (3) passive pneumonia—hypostatic, etc.; and (4) lobular. He has examined 127 cases and instituted 87 cultivation experiments, the material for the cultures being obtained one or two hours after death, as well as from the living subject, by means of a Pravaz syringe introduced into the lung and pleura. He distinguishes four kinds of microorganisms. The diplococcus pneumoniae is the most common, consisting of oval, elliptical, and round cocci, which occur in chains as well as in pairs. The chains are composed of from six to eight or as many as twenty to thirty cocci, are straight or slightly curved, and cocci are developed in a capsule of varying thickness in proportion to their vitality. The second variety resembles the first, but distinguished by a greater uniformity in spherical shape, and in forming long and sinuous chains. The third is known as the Staphylococcus aureus s. albus. The fourth he terms the bacillus pneumoniae, consisting of rods of different lengths, the smallest and apparently youngest being oval. They have a capsule, and correspond to Friedländer's pneumococcus. The first variety was found in ninety-one cases, mostly of croupous pneumonia, also in the secondary forms. The second, or streptococcus, was found twenty times—namely, in fifteen cases of primary and five of secondary pneumonia. The staphylococcus occurred in secondary cases only, and mostly where

the primary disease was due to this microorganism. The fourth kind was met with nine times, four times unmixed with other forms. All these organisms were most abundant in the earlier stages of the disease, being scanty or absent in gray hepatization, and, if present, staining badly or unencapsuled. At the margins of the pneumonic focus in the œdematous tissue micrococci were numerous, pointing to the œdema being not a passive process but a precursory stage of pneumonic infiltration, and resembling the invasion of cutaneous tissue in erysipelas. Moreover, inflammatory changes accompanied by these microorganisms were found in the respiratory tract above the lungs. Secondary meningitis in pneumonia was shown to be due to the presence of the same microorganisms, which were also found in the serous exudations of pleurisy and pericarditis, which might complicate the lung affection. The bacterial origin of the disease was, therefore, held to be demonstrated.—*Lancet*, June 12, 1886.

THE RELATIONS OF CHOLERA TO SCHIZOMYCETE ORGANISMS.—Surgeon-Major D. D. Cunningham reports the result of the examination of alvine evacuations in cholera. The cultivations were carried out with agar-agar, 1.5 per cent., as gelatin did not afford a medium which remained solid at the temperature of the air in Calcutta at the period when the investigation was conducted. Plate-cultivations were made from intestinal materials from twenty-two cases. A development of commas occurred in sixteen; in one of the other cases it subsequently turned out that the case was not one of cholera; in two others the nature of the material was doubtful; in two others the agar-agar had an acid reaction. There remained, therefore, only one case where undoubted cholera material in a favorable medium did not give a recognizable crop of commas; in this case colonies of minute straight bacilli abounded. In one case where no commas could be recognized in the original material, plate-cultivation yielded a crop. The general conclusion on this point is "that the belief

in the presence of easily-cultivable commas as a very constant and characteristic feature in the dejections and intestinal contents in cases of the disease is a well-founded one." Thirty-three samples of normal alvine materials were examined, and curved schizomycete organisms were found to be present in varying numbers in every case. In cultivations made from those materials colonies of various kinds, some presenting to the naked eye appearances closely resembling colonies of Koch's comma-bacilli, developed, but in no instance did the true comma-bacilli appear. Neither did any development of true comma colonies occur when cultivations were made from the contents of the cæcum of healthy guinea-pigs, though this material contained many curved organisms. The ponds in and around Calcutta are covered by a scum of *Euglenæ* except during the rains. The under surface of this scum is a favorable site for the development of schizomycete organisms; among these are many curved forms. Cultivations from this material in feeble alkaline agar-agar jelly yielded colonies of distinct commas.

By cultivating comma-bacilli in various media, Dr. Cunningham succeeded in obtaining varied vacuolate forms, some circular, others elliptical, such as Dr. Klein noticed in cultivations made at low temperatures. Dr. Cunningham found the vacuolation and multiplication by longitudinal splitting to be associated with acidity or partial exhaustion of the nutrient medium. By transplanting again into alkaline media and cultivating in series, typical comma colonies were obtained again on about the fourth plate. Dr. Cunningham believes that the comma-bacillus is polymorphic, and that its absence can only be demonstrated by carrying out a series of cultivations in media highly favorable to its development. Otherwise, he contends, it is impossible to prove that forms capable of being developed by such successive cultivations into typical comma-bacilli may not have been present in the original materials.—*London Medical Record*.



## Society Reports.

TRANSACTIONS OF THE FIRST  
MEETING OF THE GERMAN  
GYNECOLOGICAL ASSO-  
CIATION.\*HELD AT MUNICH, JUNE 17TH, 18TH, AND  
19TH, 1886.

(Continued from last issue.)

REPORTED BY M. WIENER, M.D., Breslau.

*First-Day.—Afternoon Session.**President, DR. WINCKEL, Munich.**Secretary, DR. KUESTNER, Jena.**Dr. Krukenberg (Bonn)* read a paper onTHE BEHAVIOR OF OLD CICATRICES FROM  
THE CÆSARIAN SECTION DURING  
SUBSEQUENT PREGNANCIES.

The reader reported briefly on twenty-six such cases found in the literature, and on another case from the Bonn clinic, in which a diverticulum formed in the uterus and was followed by rupture.

[A more complete abstract will appear in the *Arch.f. Gynæcologie*.]

*Dr. Saenger (Leipzig)* read a paper on

SIMPLIFICATION OF THE TECHNIQUE OF THE  
CÆSARIAN SECTION.

If the improved Cæsarian section is to become common property of the profession, it must be simplified as much as possible. The reader described his latest method: first, the *preparatory steps* which, aside from disinfection, are as simple as possible. *Abdominal incision* in the linea alba. Turning out of the intact uterus is not advisable, since the abdominal incision may have to be extended, and the intestines might prolapse. *Uterine incision in situ*, to be made as an anterior median section, avoiding the lower uterine segment. In case of placenta previa; rapid division of the placenta or lateral detachment. The fetus is delivered most easily and rapidly by the feet.

*Eventration of the uterus*; a napkin is spread over the intestines, another one

envelopes the uterus. Elastic ligature of the lower uterine segment, for which could also be substituted manual compression or torsion of the uterus around its longitudinal axis. Manual detachment of the placenta, disinfection of the uterine cavity (iodoform), in which is placed a sponge or a strip of gauze until the deep sutures are inserted.

*Suture.* The peritoneum is loosened and bent over; resection of the musculature is not necessary. The main point is the close double suture of the uterine wound: deep stitches embracing the peritoneum and muscular structure, but not the decidua, best of flexible silver wire, eight to ten in number; superficial "sero-serous" sutures, doubly perforating each wound margin, of fine silk, ten to thirty, according to circumstances. In the absence of silver wire, the deep sutures may be made with strong aseptic silk. In opposition to Schauta, the reader could not admit that silver wire would continue the sole material for the deep suture.

Then follow: *washing* of the uterus (sublimate 1 : 2,000); powdering the line of the suture with *iodoform*; *dropping into the abdominal cavity* only after every bleeding point has been secured by ligature. *Toilet* of the abdominal cavity only where special indications are present. *No drainage*; abdominal wound closed with button suture; dusting with iodoform. Thin adhesive plaster dressing, so that the uterus can be closely watched. Ice-bladder to the abdomen; injections of ergotin. After-treatment as inactive as possible. According to this method of the reader, 30 operations have thus far been performed, with 21 recoveries (73.3 per cent.) In the clinics of Leipzig, Dresden, and Innsbruck, there were 19 cases with 18 recoveries (94.7 per cent.)

*Dr. Schauta.* If the placenta is encountered in front, it is not immaterial whether we penetrate it directly or detach it. He thought it preferable to perforate it directly with the hand; because, in lateral detachment, more vessels are opened, and the loosened lobe crowds into the wound. The hand, and not the knife, should penetrate the pla-

\*From the American Journal of Obstetrics.

centa; then the funis can be readily felt, while the knife might possibly sever it and cause great loss of blood to the child. The fetus should be extracted by that part which is nearest to the wound; in head presentation by the feet, in footling cases by the head. He would not do without the rubber tube, owing to the great loss of blood which is entailed by the length of time consumed by suture. Saenger himself had declared for the silver wire, because it holds the wound in better apposition than silk, as had been proven experimentally. The cases stitched with silk show a greater fatality (7 out of 10) than those treated with silver wire.

*Dr. Freund, Jr.* (Strassburg), related a case of Cæsarian operation in which, despite the deep uterine suture, the hemorrhage was so profuse that the rubber tube had to be reapplied and the Porro operation performed. Then the tube was taken off and the stump dropped. Death from peritonitis. The extirpated uterus was exceedingly thin and only fourteen centimetres long.

*Dr. Kaltenbach* expressed himself in favor of the improved classical operation. The sero-serous suture had been performed in laparotomies even before the old Cæsarian section had been modified. Saenger's merit is, that he has rehabilitated the old Cæsarian section, in comparison with the Porro operation, and has extended the indications for the operation in view of the better results obtained. Of Saenger's method nothing had remained but the sero-serous suture. Very good results can also be obtained with thoroughly disinfected silk.

*Dr. Fehling* likewise spoke in favor of the improved Cæsarean section. He would turn out the unopened uterus through the abdominal incision, since the length of the latter and prolapse of the intestines are of no consequence. Then the elastic tube can be applied before the uterus is opened—a matter of importance especially in reference to the needs of the general practitioner. He, too, would extract the child by that portion which is pressed into the wound. Silk he thought to be the suture material of the future; sewing with silver wire has to be learned, particularly the

knotting of it. Good silk, provided it do not project into the uterus, cannot be dangerous.

*Dr. Zweifel* was likewise in favor of the improved classical section, especially since there had been added the modification which does away with the resection. The Porro operation he would no longer employ.

*Dr. Leopold* believed it also more correct, particularly in view of the needs of the general practitioner; turn out the uterus; the abdominal incision would not thereby become excessively enlarged. The elastic tube is fastened with compression forceps, and a temporary abdominal suture inserted to guard against prolapse of the intestines. The child is not injured by the constriction. The loosening of the peritoneum is not essential. Should the wound tear during the extraction of the child, especially downwards, it is good practice to do some resecting, that is, to smoothe the wound. He sews with stout wire; the superficial sutures are of strong silk. The narcosis must be profound and undisturbed. With a view to guard against after-hemorrhages, he gives injections of ergotin. Atonic after-hemorrhages had not occurred in his cases. As he loosens the elastic ligature, he compresses the uterus with the hand, so as to excite a pain.

*Dr. Krukenberg*, like Freund, had observed a profuse hemorrhage after the uterus had been sutured. The patient died. A clot the size of the fist was expressed from the uterus. At the autopsy, the anemia found was not great enough to explain the cause of death. The fatal issue may have been due to air-embolism and hemorrhage. He believed that atony of the uterus may occasionally render the employment of the elastic ligature dangerous.

*Dr. Schauta* lays the greatest weight on the rigidity of the suture material; he rejects silk, not because he fears infection, but on account of the mechanical injuries (too firm ligation, strangulation) inflicted on the tissues; he attempted to prove by a citation from Saenger's monograph that the latter had not prized the silver suture formerly as highly as at present.

*Dr. Saenger* replied that not only his



papers, but his operations demonstrated that he prefers silver wire for the deep sutures. Schauta should not lose sight of the fact that he had at the same time employed the sero-serous silk suture. Silver wire alone also gives good results; Simon Thomas had obtained with it four recoveries out of six cases. It seemed Schauta did not dare to use the wire alone. The speaker claimed as his own merit that he had been the first to apply very numerous sutures, and to have shown that catgut—*i. e.*, absorbable material—should be avoided; he had also laid stress on accurate coaptation.

To Krukenberg he replied that he had given in his monograph an accurate collation of cases with Cæsarean cicatrices together with an analysis of their origin.

*Dr. Winckel* inquired whether anybody was able to give information regarding the state of Cæsarean cicatrices and silver sutures at the repetition of the operation.

*Dr. Saenger* knew only of the one case by Lungren, who describes the cicatrix as uniformly smooth, and says that the silver sutures looked as if they had just been inserted.

*Dr. Winckel* exhibited a rabbit which had been successfully inoculated (subcutaneously) on the ear and back with the blood from the heart of a puerpera dead of external and internal erysipelas. He also showed specimens of the erysipelas cocci bred from the blood.

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A CASE OF REFLEX EPILEPSY CAUSED BY THE LARVÆ OF FLIES.—By Dr. Krause in *Deutsche Med. Wochens.*

A tanner, aged 40, had a typical epileptic attack. There was nothing to account for it in the man's habits or constitution, and no family history tending towards epilepsy; still, as the attack was undoubtedly epileptic, bromides of potash and ammonia were given and a purge to relieve the constipated bowels. This last acted speedily, and, to the patient's "horror or joy," the stool was one mass of swarming life, much like a disturbed anthill. This lively mass was composed of the larvæ of the blue bottle

—*musca vomitoria*—and of another fly—*antomyia canicularis*. There were perhaps 1,000 larvæ in the stool, and as soon as they were parted with the feelings of oppression and anxiety with which the patient had been afflicted, vanished, and neither they nor the epileptic attack returned.

The larvæ of these flies abound in raw hides, and at first Dr. Roth was inclined to attribute their presence in this case to the man's occupation, but the vast numbers led him to think it more probable that they had been swallowed in cold meat, and had developed to their final size in the stomach and intestinal canal.

He concludes by remarking that in the text books, in a general way, reflex epilepsy is said to be sometimes caused by parasites in the intestine but that the writer usually tags to that remark his own personal doubts, and that, therefore, a decided case like this is worth publishing.—*Medical Chronicle*.

MODERN HEMOSTATIC METHODS.—In the *Centralblatt fuer die gesammte Therapie*, March, 1886, Felix Schwarz, in speaking of styptics, rejects the perchloride of iron, as incompatible with the aims of modern surgery. At Billroth's clinic, the only styptics employed are adhesive iodoform-gauze, tannin-iodoform-gauze, and tampons of Penghawa-Dyanbi with iodoform.

These dressings are as reliable as the iron and have the preference of absolute antisepsis and cleanliness. No sanious supuration follows the application of these dressings. The smeary appearance of a wound treated with the perchloride is well known.

The adhesive iodoform gauze is prepared by moistening the ordinary carbolized gauze and cutting into suitable strips; the iodoform is then dusted on and rubbed into the fabric, which holds it by reason of the rosin contained in it. The tannin-iodoform-gauze is prepared by substituting equal parts of tannin and iodoform for the iodoform. The Panghawa-tampons consist of a vegetable product that is not further described.—*Med. Review*,

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, SEPTEMBER 4, 1886.

**Editorial.**

DR. BILLINGS ON MEDICAL EDUCATION IN AMERICA.—The annual address in medicine before the British Medical Association, was to have been delivered by the lamented Austin Flint, on the 11th of August, but owing to his unexpected death, Dr. John S. Billings of the United States Army was invited to fulfil his unaccomplished task. In his address, Dr. Billings presented to his audience the subject of "Medicine in the United States and its Relations to Coöperative Investigation," and it is safe to say that the English profession now understand the peculiar conditions surrounding the study and practice of medicine in this country as they have never done before. We must omit all notice of many portions of Dr. Billings' admirable address, but his remarks upon the standard of medical education strike us as being peculiarly appropriate. It is hardly possible for physicians practising in Great Britain, where there is an enormous population crowded into a small space, and where likewise there is enormous wealth, to understand the trials and besetments of the American country practitioner.

In regard to the complaint that the standard of education is too low. Dr. Billings says this is true for some localities but not for others. "A man may be fairly qualified for practice in one part of the country and yet find himself at a loss in another. \* \* \* I need hardly tell you that the physician who

has received his chief clinical instruction in the office of his preceptor in Vermont or New Hampshire, supplemented by distant glimpses of a few cases in a Hospital in Boston or New York, will find himself at a loss at first in dealing with the emergencies of daily practice in Arkansas and Mississippi. He will be subjected to influences which are at times dangerous to one who is not acclimated and which tend to produce depression of spirits, want of energy, and bad health. Moreover, the pecuniary reward which the practitioner in many of these places can hope for is comparatively small." As is truly stated by the orator, it is not to be expected that a man will spend six or eight years in study and \$5,000 to \$10,000 in money, and settle in a country where the emoluments are from \$700 to \$1,000 yearly. Nevertheless it was in such a country that Sims laid the foundation of modern gynecology, and that McDowell, Battey, and Gross labored in the domain of abdominal surgery. The same standard of education for rural districts and the large cities cannot be adopted without rendering the grade so low as to be ridiculous and useless. "The demands are widely difficult, and corresponding differences exist in the sources of supply—that is, in the medical schools." "The proverb that it does not pay to give a \$5,000 education to a \$5 boy is clearly of American origin, and sums up a great deal of experience."

Dr. Billings goes on to say that public opinion is to a large degree responsible for the character of education, and there can be no efficacious legislation in regard to the practice of medicine which is not in accord with public opinion, since it is impossible to continue to punish for any length of time that which the public does not condemn. The remedy then must be applied to the public rather than to the profession. Very much in the same vein was the address of Professor Bartholow before the Alumni Association of the University of Maryland in 1882. He says, "on all sides the low condition of our medical teaching is deplored, and the standard of our medical schools is unfavorably contrasted with European models. Much of this



discussion is a wild declamation, more concerned for the effect it produces than for an exact statement of the facts. Our medical schools must be considered in relation to the state of American society, to the degree of general cultivation to which the people have attained, and to the condition of the medical profession." "An uncouth and ignorant people would not appreciate—would not indeed understand, a polished physician full of the culture of the schools. Prof. Charcot and Sir William Jenner equipped with all the resources of scientific medicine, would fail to please the people of Egypt in Southern Illinois, when a botanical physician with lobelia and No. 6 would excite their enthusiastic admiration." Dr. Billings makes the same statement, but in somewhat different words: "So far as the art of medicine is concerned, the demand has much, though by no means all, to do with regulating the quantity and quality of the supply; and there are few localities in the United States where the qualification of the medical man is not fully up to the standard which the community is able to appreciate and is willing to pay for. In the natural order of things, suffering and death are the remedies for ignorance, weakness and vice, and the means of preventing the transmission of these characteristics to offspring. These remedies though effectual, are drastic, and we do our best to avoid them, but perhaps it is well that the penalties cannot be done away with altogether." We are thoroughly in accord with these views. We believe, as is stated by the orator, that in all our cities and very often in the rural districts also, there is a large class of medical men who are as well educated, and as well prepared to practise their art, as can be found in the world, but in many remote or thinly settled and impoverished sections, only those are able to subsist whose education has cost but little or nothing, and whose qualifications are meagre; the medical man tilling the soil perhaps during the day and visiting his patients at night. Notwithstanding the many portals of entrance to the practice of medicine in this country, and the limit-

ed qualifications which are required even by our largest and most flourishing colleges, we do see a slow but continuous advance in the standard of medical education. Much has been already done in this direction by Harvard, the College of Physicians and Surgeons of N. Y., and the University of Pennsylvania, and now that the bequest of the Vanderbilts Carnegie and Johns Hopkins are either available, or will be in the near future, for the promotion of medical training, we may expect the next decade to show a still greater advance in the development of American medicine. It is not improbable that the example set by the great surgeon Dr. Thomas Keith, of Edinburgh, in sending his son to New York to study American gynecology, may be followed by others, not only in this specialty, but in the whole range of medicine, until it may be as common for foreign physicians to come to our shores, as it now is for Americans to visit the great centers of Europe.

GONORRHOEA CONTRACTED FROM RECTAL COITION—The *Medical News*, of August 14, contains an article from the pen of Dr. Randolph Winslow, of this city, in regard to an outbreak of gonorrhœa contracted from rectal coition. During 1883 and 1884, a series of cases of urethral gonorrhœa occurred in a certain institution, where the surroundings were such as to render it certain that the disease was not contracted in the usual manner from women. Briefly stated, the facts are as follows: There is a certain institution near Baltimore in which a large number of boys reside, and these boys with a few exceptions enjoy only a very restricted liberty, as an eighteen foot stone wall encloses the premises, and the inmates are seldom beyond the sight of an officer. No females were employed at the institution, except middle aged women as cook and laundress, and owing to the rigid surveillance it would have been impossible for the boys to have had ellicit relations even with these women. Notwithstanding these facts, numerous cases of gonorrhœa and epididymitis occurred amongst the boys, the origin of which

for a long time remained a mystery. The authorities were certain that the boys had had no opportunity to have connection with women, as some of those with the disease had not been outside of the institution for several months, and the affected youths ascribed the trouble to such causes as straining, masturbation, and wearing the shirt of another. Finally, however, the origin of the outbreak was traced to sodomy. This vice had been practiced occasionally, but without any apparently ill effect upon the health of those indulging in it, but upon a certain occasion a boy who was absent upon leave of absence contracted gonorrhœa in the usual manner, and after his return he cohabited with one of the boys, and produced proctitis of a gonorrhœal character. Similar favors were granted other boys, and as a result a number of cases of urethral disease were set up, and so the disease spread from one to another, until at least ten had been infected with gonorrhœa and epididymitis. Some of these cases were severe, and one was very ill with gonorrhœa of the urethra and metastatic abscesses in various portions of the body. As several of these cases came under the personal observation of Dr. Winslow, and the others under that of an equally reliable observer, the authenticity of the facts recorded can scarcely be doubted. The occasional occurrence of gonorrhœal inflammation of the rectum is vouched for by a number of authors and is denied by others, but it seems pretty well proven that such a condition does occur. Dr. Winslow examined the rectum of two of these boy prostitutes, and found evidence of inflammation in each, increased vascularity, pain, and tendency to bleeding; whilst Dr. John Morris, of this city, records in this JOURNAL, June 1st, 1882, the case of a lady who suffered from rectal gonorrhœa, the chief symptoms of which were pain, spasmodic contraction and fornication. It is evident then that rectal gonorrhœa does occur, either from the inflowing pus from the vagina in women, or from pæderasty in both sexes. So far as we have known, however, the cases recorded by Dr. Winslow are

unique; at least we have never heard of urethral gonorrhœa being contracted in this manner, and they afford an interesting addition to the literature of this disease. In this connection we recall the statement of the Apostle Paul, as recorded in the first chapter of the Epistle to the Romans, "And likewise also the men, leaving the natural use of the woman, burned in their lust one toward another, men with men, working that which is unseemly and receiving in themselves that recompence of their error which was meet." By the law of the land sodomy is considered a crime, to which a severe penalty is attached, and those who indulge in it are sure sooner or later to receive some "recompence of their error," whether that be gonorrhœa or corporeal castigation, or simply the consciousness of having done an act which no beast except man is guilty of committing.

### Miscellany.

ON THE THERAPEUTIC VALUE OF PREPARATIONS OF COCA IN CHILDHOOD.—Professor Pott, of Halle, records some experiments with coca. He used a tincture composed of one part coca leaves to five parts of absolute alcohol, and an extract internally, and solution of the strength of five and ten per cent. of cocaine for subcutaneous injection and external application. He found the tincture, in doses of from five to twenty drops every hour or two hours, of the greatest benefit in the various forms of enteritis, gastroenteritis, colitis and cholera nostras, in children under two years of age. Even in very severe and desperate cases, after from fifty to one hundred drops of the tincture had been taken—*i. e.*, within about twenty-four hours—the sickness stopped, the diarrhœa was greatly lessened, and a permanent improvement set in. Part of this improvement may have been due to the alcohol, and the ordinary rules for diet and hygiene were at the same time rigidly enforced. He found no benefit from its use in diseases of the respiratory tract or of the nervous system. The extract was not fully tried, but seemed of some



use in the nervous attacks of older children. The chief novelty in his use of the cocaine solution was in its application in whooping-cough. He found that painting a five per cent. solution on the back of the throat three times a-day had an immediate and strikingly beneficial effect on the paroxysms, reducing them at once in number from twenty or more during the twenty-four hours to three or four, and is of opinion that the course of the disease may be shortened by some weeks by this method of treatment. He found the same application very useful in cases of inflammation of the tonsils and pharynx, and in various forms of angina.—*Edinburgh Medical Journal*, June, 1886.

**SOFT CHANCER OF THE MIDDLE EAR.**—The *Gazeta Lekarska*, a Polish medical journal, contains a report by Dr. Guranski of a case of soft chancre of the middle ear. The patient was a woman with a phagedæmic chancre of the genitals, who from snuffing tobacco managed to introduce the virus into the nose, where the septum had become ulcerated, with copious discharge of foul pus. From this the infective material must have passed through the Eustachian tube into the middle ear. Deafness and pain were complained of, and subsequently perforation of the tampanic membrane occurred, a large quantity of purulent matter being discharged through the opening and infecting in its turn the external meatus. The case was treated by the introduction of iodoform into the ear and nose, and by injecting warm water through the ear by means of the Eustachian catheter. In a month's time the patient regained her power of hearing and completely recovered. Dr. Guranski has a great belief in the efficacy of washing the middle ear with warm water, having seen cases of severe inflammation recover under this treatment where it was feared that the only hope of saving the patient's life lay in trephining the mastoid process.—*Lancet* August 7.

**A CASE OF HERNIA OF THE BLADDER THROUGH THE VULVA, WITH STRANGULA-**

**TION.**—The patient was a woman with deformed pelvis, who, after severe labor, had an enormous vesico-vaginal fistula. She had consented to an operation for the obliteration of the vulvar orifice, but left the hospital before this could be done. The following year she returned in a very bad state. On examination, a tumor of the size of an orange, of a violet color, was seen protruding between the labia, and this turned out to be the bladder gripped at the entrance to the vagina. Any manipulation of the tumor was attended with great pain and considerable hemorrhage. The obliteration of the vaginal aperture was again suggested, and this time was agreed to and performed under an anæsthetic. The labia minora and the internal surface of the labia majora were cauterized by means of the thermocautery, in order to secure large granulating surfaces. These were approximated by means of sutures carried right through, and the labia of the opposite sides were brought securely into contact. Obliteration of the vulvar orifice was thus obtained, a small orifice being left below the meatus urinarius. After the operation no urine escaped while the woman was recumbent, and only to a small extent when erect. It was proposed to fit on a sort of receptacle, but she left before this had been prepared. Some months later, she returned once more as bad as ever. The vesical hernia and strangulation had recurred; and although the vulvar orifice was smaller than in the first instance, the effect of the former operation had been almost entirely destroyed, the husband and the surgeon having apparently worked at cross purposes. Dr. Polaillon considers the case of interest on account of its rarity.—*Archives de Tocologie*.—*London Medical Record*.

**THE PREVENTION OF GENERAL TUBERCULOSIS BY REMOVAL OF LOCAL AFFECTIONS.**—In an article on this subject in the *Archives Générales de Médecine* for April and May, 1886, Dr. A. Marfou broaches the theory that tuberculosis belongs to that class of infectious diseases—among which are syphilis,

scarlatina, etc.—in which one attack confers immunity against others, as a rule, and he therefore argues that all accessible local tubercular affections should be removed as speedily as possible. He has collected a number of observations of individuals presenting evidences of cured tubercular adenitis, living for many years as nurses in hospitals, and surrounded by phthisical patients, who never betrayed any symptoms of subsequent tubercular infection. He has also examined a number of persons who had been cured of lupus, and never found any symptoms of pulmonary disease. He believes that scrofulous adenitis occurring in childhood confers immunity against tuberculosis, while a similar affection, first appearing in adult life, is usually accompanied by tubercular disease in the lungs. He says it is very rare to find patients suffering from pulmonary phthisis who have any marks upon them pointing to a previous adenitis or lupus, and he regards the latter affections as caused by an attenuated form of tuberculous virus. Auto-inoculation he regards as very exceptionable, and is consequently in favor of removal by operation, wherever practical, of local forms of the disease.—*Med. Record.*

THE PREVENTIVE TREATMENT OF SYPHILIS.—Charles E. Jennings writes to the *Lancet* as follows: My object in publishing the case of Mr. A. B. C. was to afford a contrast to the ordinary treatment of early syphilis, which I believe to be opposed to the best interests of the patients, and which might be described as follows:—A surgeon, upon seeing a patient with a primary chancre, is frequently perplexed—especially if he lack much experience in the diagnosis of syphilis, or if the lesion be immature and its physical characters not strongly pronounced—as to the recognition of the disease before him. Only too often the advice given is to wait until the diagnosis is concluded satisfactorily by the appearance of secondary symptoms before resorting to specific treatment. A sore-throat and corona veneris having appeared in due course, the patient is now informed that he certainly is the subject

of syphilis, and that its virus really *was* implanted some weeks previously—that is, just before he applied for treatment. An eighteen months' or two years' course of mercurial treatment is now rigorously prescribed, and the subject of the experimental diagnosis comforted by being told that the delay consequent thereon has not materially retarded or diminished his prospect of a cure (in about two years' time). Surely a consideration of the pathogenesis of syphilis shows that the converse is the right line of practice. Every reasonable practitioner knows very well that the *earlier* the treatment of syphilis is commenced, so much the better is the prognosis, and therefore to withhold specific remedies for the sake of establishing scientific observations is equivalent to conducting an experiment highly detrimental to the patient.

Making full allowance for the conflicting evidence which still envelope the theory of the absorption of the virus, I incline to the view that the system is not perfectly invaded by the poison before the maturation of the chancre, and that a thorough destruction of it, whilst immature, will modify, if not arrest, specific contamination. In the case of Mr. A. B. C., I was morally convinced from the history, coupled with the physical conditions presented, that I had destroyed an immature chancre, and Sir William Jenner, who saw the patient with me, accept this view as correct. Drs. Harries, Johnston, and Craig (who did *not* see the patient) think otherwise. But the idea of withholding specific treatment never occurred to Sir William Jenner or myself, and I am quite sure Mr. A. B. C. would not have desired that course in order that an opportunity for the appearance of secondary phenomena might have been afforded to establish the diagnosis to the satisfaction of anyone who might be sceptical upon the subject. Permit me to repeat that the destruction of a primary chancre with Paquelin's canter, the growth being previously painted with a solution of cocaine, is a very trifling surgical procedure; and I should think that to excise the infected lymphatic glands also would,



in some cases, be a most rational mode of treatment. The criticisms offered by the gentlemen referred to, although very interesting, have little bearing upon the point at issue. It seemed to me that the publication of a solitary case might possibly prove of benefit to the profession and community, as being descriptive of a simple plan which could be tested without delay by any practitioner who might incline to imitate the practice.

**ALCOHOL IN HOSPITALS.**—Dr. Drysdale, leading physician of the Metropolitan Free Hospital of London, England, lately read a paper before the British Medical Temperance Association on the above topic, in which the following conclusions were prominent:

1. Alcohol is not a real food, but must be classed among the anæsthetics, in company with ether and chloroform, hence it ought not to be used as an article of ordinary diet.

2. The treatment of fevers by alcohol in large quantities is inferior to the treatment by cold and ordinary diet.

3. There is no clear proof that alcohol is changed into carbonic acid and water in the system; and, at any rate, part of it remains unchanged for as much as twelve hours in the system, irritating the internal organs.

4. Moderate amounts of alcohol neither raise nor lower the temperature, but excite the heart's action, and in some cases, in small doses, less than one ounce gives appetite.

5. In large and stupefying doses, alcohol lowers the temperature.

6. The amount of alcohol administered in various hospitals is so wanting in uniformity as to show that there is no settled opinion in the profession at present as to its value.

7. It would be well, when alcohol is prescribed in clinical hospitals, that some exact amount of it should be prescribed, and not a varying amount of an alcoholic fluid not analyzed.

8. The London Temperance Hospital experiment seems to indicate that many diseases do well without the use of any alcohol, which previously were thought to require it.

9. Hence, whilst the modesty of science forbids us to say that alcohol will prove useless in any given disease, it seems advisable for patients in hospitals to have that drug administered to them with far greater caution than has hitherto been the case. And it would seem also to follow that all mere dietaries should be free from the routine use of alcohol, which should in all cases in hospitals be distinctly ordered to the patient by his medical adviser.—*Quarterly Journal of Inebriety*, July, 1886.

**LIGATION OF THE VERTEBRAL ARTERIES FOR THE RELIEF OR CURE OF EPILEPSY.**—In a paper on this subject in the *Neurological Review*, Dr. J. L. Gray arrives at the following conclusions:

1. Ligation of the vertebral arteries should take its place as a recognized procedure in the treatment of certain cases of epilepsy.

2. The operation should be confined to those cases in which the exciting causes of the attacks come from some region outside the brain.

3. The arteries should be tied as high up as practicable, and the ligature should include all the fibres of the sympathetic accompanying the vessel.

4. Where the side of the brain which is first invaded by the disease can be determined, the artery of that side should be ligated.

5. Where the invasion of the disease is apparently bilateral, both vertebrals should be ligated.

6. This operation should not be done as a substitute, but as an aid to other forms of treatment for the relief or cure of epilepsy.

**ON CONTUSION AS A DETERMINING CAUSE OF NEOPLASMS.**—We all know how much the question of the rôle of contusion has been discussed in the development of cancer and tumors in general. For my part, I have always admitted this cause not only for the malignant new growths, but also for the most benign, such as cysts, lipoma, etc. One of my internes, M. Le Clerc, has, under my directions, accumulated a quantity of material, and has prepared a thesis

giving the actual state of our knowledge upon this subject. The following are the conclusions reached in his thesis. 1st. Contusion has an undeniable rôle in the etiology of neoplasms. 2d. It acts by exaggerating the reparative process going on in the centre of the tissues, and by creating in the wounded part a *locus minoris resistantiæ*. 3d. It is, however, only a localized cause, and cannot produce by itself a neoplasm; to do so it needs a diathesis that we will call neoplastic, which is secondary, and depends upon arthritism.—*Prof. Verneuil in Med. Times.*

**IODOFORM POISONING.**—Bum arrives at the following conclusions:

(1) Iodoform has a poisonous action when the iodine freed in the organism does not become perfectly combined.

(2) This poisoning will happen where the quantity of iodoform introduced is 1, over large, 2, and in qualitative and quantitative changes of the blood. It is surest to occur where these two forces work together.

(3) The use at once or in short intervals of very large quantities of iodoform, especially in anæmic, very young and old individuals is to be avoided.

(4) The iodoform dressing is to be changed as seldom as possible in order to avoid a cumulative action, (and at the same time the iodoform is not to be removed the wound washed and fresh powder or other form applied, as a surface the best suited for absorption is left.)

(5) The iodoform in the wound must never be exposed to a strong pressure as it aids absorption; the dressing is therefore never to be applied tightly.—*Boston Med. and Surg. Journ.*

**UNILATERAL PRURITUS.**—Joseph (*Berlin Klin. Wochens.*, No. 30, 1885), in the case of patient suffering from complete paralysis of the left side following heart-disease and emboli, observed marked pruritus confined to the affected side. The latter showed loss of motion and sensation, diminution of temperature, the heat of the body diminished, knee-reflex absent, and, while the skin was

soft and the sebaceous secretion normal, an abundant perspiration which for weeks was observed on the right side was quite absent from the affected one. A factitious urticaria which was brought out over the whole body was much more marked on the healthy side, where also the quaddels were more persistent.

The treatment consisted in rubbing in the following twice daily:

℞ Chloral hydrat.,  
Camphor crystal., āā 3j;  
Vaselin, 3 x. M.

This diminished the pruritus greatly and gave the patient rest.—*Med. Times.*

**HYSTERECTOMY AND NEPHRECTOMY.**—*La Gazzetta degli Ospitali* (July 21st) reports a successful operation by Professor Calderini, of Parma, for the removal of the entire uterus. The organ had been completely prolapsed for some time, and was the seat of multiple sub-peritoneal myomata. The temperature after the operation never exceeded 37.7° C. Of six vaginal hysterectomies, four were successful in the hands of Professor d'Antona, of Naples. This operator has devoted much attention to renal surgery. He prefers lumbar to abdominal nephrectomy, and thus summarises the statistical results of the two operations up to this date. In 111 lumbar nephrectomies the percentage of mortality has been 39.93, whereas the abdominal method practised 120 times is said to have yielded a death-rate of 50.83 per cent.—*Lancet*, July 21, 1886.

**MEDICAL INCOMES IN CANADA.**—The "Evening Post" quotes from the "Toronto Globe" as follows: "There is only one medical man in this city who last year earned \$5,000 from his profession, combined with the interest he received on his previous savings. There is not one man on the list who had \$4,000, and only four who touched \$3,000. When we come to the comparatively modest and moderate \$2,000, we naturally conclude that we shall have a full legion. But no, we have only fourteen all told who come up to this figure. When we come to between \$2,000 and \$1,000 the number becomes encouragingly large.



As many as fifty-one of the best-known greatly-sought-after doctors of our city are put down under their own hands and seals as having last year lived on from \$1,000 to \$1,800. Some of these are professors. There remain only the unfortunate who worry along with from \$800 down almost to zero. Of these, we are sorry to say, there were last year thirty-six.—*N. Y. Med. Journ.*

THE TREATMENT OF ERYSIPELAS.—An interesting contribution to the treatment of erysipelas emanates from the University Clinic of Professor Kraske, of Freiburg, Dr. G. Kuehnast being the reporter, in No. 9 of the *Centralblatt für Chirurgie*.

Kuehnast formulates his views as follows:

1. The treatment of erysipelas by multiple scarifications and incisions, with subsequent application of carbolic acid, is the most effective method at our disposal.

2. The method is not to be recommended in cases of light erysipelas, and in cases of erysipelas of the face or of other exposed surfaces.

3. Certain modifications may be practiced. Thus, in extensive erysipelas in decrepid individuals, the scarifications may be limited to the margins where the process is progressive.

In children and old people it is advisable to substitute salicylic or boric acid for the carbolic acid washings and dressings.—*Weekly Medical Review*.

MEDICAL SOCIETIES.—The season is drawing near when the various medical societies throughout this country will be commencing their campaign for the fall and winter, and a word of suggestion may not be out of place. As a rule, the various county medical societies embrace in their lists of membership the great majority of the reputable physicians of the county, but it is an equally general rule that their meetings are attended only by a handful of the members.

A discussion on the International Medical Congress, or an attack on the American Medical Association, will pack

the meetings to suffocation; but the ordinary scientific gatherings are disheartening, gloomy, and funereal affairs.

Why? Because the intellectual feast prepared is not sufficiently attractive to magnetize the members. Who, of late years, for instance, has heard the voice of Agnew in the hall of the Philadelphia County Medical Society? In former years, when he was comparatively obscure and unknown, he was ready enough to talk; but now, when *all* would flock to hear the pearls of wisdom that would drop from the lips of his mature experience, he is noted only by his absence. We pen these few words to remind our *distinguished* men that they owe a duty to the profession that they do not fulfil.—*Medical and Surgical Reporter*.

MICROBES AS FACTORS IN THE FORMATION OF FOREIGN BODIES AND CALCULI.—At the Paris Biological Society M. Galippe stated that he had examined arthropytes removed from a knee, and had observed microbes in them the same as he had detected in calculi removed from the bladder; he had isolated them and cultivated them. This investigator is, therefore, confirmed in his belief that the crystalizations found in the human economy develop through the agency of microbes; then, microbes are pathogenic parasites of the foreign bodies of the animal economy, whatever may be the chemical composition of these bodies and wherever they may be found.—*N. O. Med. and Surg. Journal*.

### Medical Items.

Surgeon-General Murray, of the United States Army, was placed upon the retired list on August 6.

Amongst the American physicians in attendance on the meeting of the British Medical Association, were Drs. Frank Donaldson, and H. P. C. Wilson, of Baltimore.

Dr. Thomas A. Ashby, editor of this JOURNAL, has been enjoying a much needed vacation in the blue grass region of Kentucky. He will resume his editorial duties with the next issue.

DOCTOR LAWSON TAIT.—The honorary degree of M.D., has been conferred upon Mr. Tait, by the University of the City of New York. We wish for Dr. Tait, the same marvellous success which has attended the labors of plain Mr. Tait. Dr. Tait's father was Friend Tait, a worthy quaker.

Dr. Henry M. Thomas, son of Dr. James Carey Thomas, has returned from a protracted sojourn in Europe, where he has been pursuing post-graduate studies in Heidelberg, Berlin and Vienna. He has devoted his attention chiefly to the diseases of the nervous system.

*The Pacific Record of Medicine and Pharmacy*, edited by Charles W. Moore, M.D., and published in San Francisco in the English and Spanish languages, is before us. The first number is attractively gotten up and we wish it success. The editor hopes to make the *Pacific Record* a valuable means of communication with the Spanish speaking States of America.

BOUGHT A CHURCH.—The Baltimore University of Medicine, which recently purchased St. James's Methodist Episcopal Church South, on North Bond, near Baltimore street, has removed its free dispensary to the building, and have many important changes in progress. Among the improvements will be two large lecture rooms, two hospital wards, office and faculty-rooms. It is expected to be ready for fall lectures. The Sisters of Charity will have charge of the sick, and as soon as possible apartments will be erected for their accommodation.

A WONDERFUL OPERATION.—We learn by an account in a recent issue of the *New York World* that another rare and wonderful operation has been performed with brilliant results. This time it was a very painful cancer, situated in the dangerous locality of the breast. The skillful surgeon at the hospital was willing, however, to take all risks to save the life of the patient. The incisions were carefully and judiciously made "in the direction of the fibres of the great pectoral muscle," the slightest deviation of the blade inviting death. The knife was carried "around the diseased mass in such a manner as to include every part of it, the lower incision being made first." The pectoral muscle was "thoroughly exposed by the removal of its fibrous envelope." "Strict antiseptic precautions" were observed, and, *mirabile dictu*, the wound "healed by first intention," without any increase in the temperature. All this shows what advances are constantly being made in our noble art by bold and skillful surgeons. We hope, however, that success will not make some of our operators too bold. Who will be the first one to tackle "a wen?"—*N. Y. Med. Record*.

Pork as an article of food has often been accused of producing a tendency to scrofula, but evidently with great injustice, for we have seen that the Jews who never eat it are al-

most universally scrofulous, while the Southern negroes, whose staple animal food it was, were conspicuously free from it.

\* \* \* \* \*

A practice existed among Southern negroes (and to some extent also among the whites) before the emancipation, which at first I was inclined to condemn until I saw the excellent effects resulting from it. Within an hour or two after birth a piece of fat salt pork or bacon was placed between the child's lips, and it was permitted to suck this at all times when not nursing. Tied to its wrist by a short string, so as to prevent swallowing it, this piece of pork furnished both nutrition and amusement to the child many hours while the mother was at work in the field or garden. The children threw well on it, and thus treated, we found them to be well developed at twelve months as most children at twenty. It was doubtless due in part to this practice that there was so little scrofula among them.—*Dr. Jno. S. Lynch, Article on Scrofula. Pepper's System of Medicine.—Cleveland Medical Gazette.*

PEN PICTURE OF LAWSON TAIT.—Mr. Tait is a much younger man than I had expected to find him. He is just forty-one years of age; he is about five feet nine inches in height, and weighs, I should say, two hundred and twenty-five pounds. His legs are short, body quite long and large; hands short and fat, but how nimble and dextrous! His hair is dark-brown, slightly sprinkled with gray, and he wears it quite long. He has a full face, with short side-whiskers. His voice is pleasant and manly, and his whole make-up impresses you as belonging to a person of immense force. His manners are pleasing, and to friends cordial. I should say he was a good lasting hater. He is a native of Edinburgh, and was a pupil and very intimate friend of the late Sir James Simpson, to whose pictures he bears a striking resemblance. He does most of his operations before breakfast, and seems to be in a big rush during all the day.—Letter from W. O. Roberts, in the *American Practitioner and News*, August 21st, 1886.

At a meeting of the Alumni Association of the College of Physicians and Surgeons, held August 23, 1886, the following was unanimously adopted:

*Whereas*, We, the Alumni Association of the College of Physician and Surgeons of Baltimore, deeply regret the premature death of our friend and associate, Dr. L. L. Bitting.

*Resolved, therefore*, That by his death the profession loses an intelligent, diligent and progressive exponent, and our Association a worthy, energetic member, an earnest, warm-hearted friend.

That we extend to the family of the deceased our sincere sympathy.

That these resolutions be inscribed upon the minutes, published in the city papers and the MARYLAND MEDICAL JOURNAL, and that a copy be sent to the bereaved family.

SPENCER M. FREE, }  
J. H. BRANHAM, } Committee.  
J. W. CHAMBERS, }



Original Articles.

AURAL REFLEX PHENOMENA.

BY J. G. WILTSHIRE, M. D.,

Clinical Assistant in the Baltimore Eye, Ear, Throat and Chest Charity Hospital.—Physician to the Baltimore Orphan Asylum.

During my college days it was a source of wonderment to me that so few lectures were devoted to aural surgery; and since my opportunities for studying the subject have been ample, and that I have found so many missing links, explanatory phenomena that have hitherto made me lay my books down more than once, and wish for a guide to the portals of truth in this branch of medicine; and it has been still more surprising to me that so few of my devoted colleagues have given their attention to this special work.

I have gleaned some facts from my field of labor that I take pleasure in giving to those who have not had the good fortune to explore these labyrinthine walks.

And as I have nothing original to offer, I shall state in the beginning that I have been guided by my clinical experience and the best authorities in deducting my conclusions.

I have taken for my subject aural reflex phenomena; and before I begin my structure I shall lay my ground work. To obtain a reflex action it is necessary to have such machinery as will produce an impulse in a sensory or afferent nerve, which is connected with a motor or efferent nerve by certain central irritable nerve cells, and the motor nerves connected in turn with some "irritable tissue elements," so that the impression made on the sensory nerve, at any point along its course, is conveyed by it to these irritable cells, and these, by molecular action, transmitted into a reflex action. Such an advent occurs to the iris when its pupil dilates in certain external ear troubles. Here the impulse is created in the end organs of the auricular branch of the vagus, and conveyed, as a reflex action, by the vagus to the "superior cervical ganglion" of the

sympathetic, thence to the "superior" (Budge), which presides over dilation of the pupil.

Impacted cerumen, and other foreign bodies in the external auditory canal are most potent causes of reflex phenomena, such as epileptiform symptoms, tinnitus, vertigo, and indeed a sense of weakness in the arms and forearms can be produced by this cause. All or either of these symptoms are suggestive of troubles of some gravity to the laity; indeed, the physician in attendance, if not most guarded in gathering his facts, may fall a victim to his own misguidance. A man presents himself to you with impacted cerumen in either, or both ears, and with expressions of fear of brain trouble pending; he gives vertigo as the most prominent subjective symptoms in his case. No wise physician would disregard this symptom, for it often portends just what the patient suspects; but to come at the true source of the unpleasant symptom is the desideratum, and the employment of all the therapeutics would be nugatory if the offending body were not removed. This you do very readily by first softening the wax by the instillation into the ear of an 18 gr. sol., sodii bicarbonatis, and then syringe with warm water.

What explanation can I offer for this, another of nature's freaks? She explains herself most ingeniously by linking the auricular branch of the vagus, the sensory supply to the external auditory canal, with the inferior cervical ganglion of the sympathetic, from which the inhibitory vaso-motors to the vertebral artery are derived; this line of communication once established, one can readily see how irritation of the meatus externus could finally inhibit the tonus of the vertebral artery—this done the latter artery and its branches would become engorged, thus causing congestion of the internal ear (through the internal auditory artery, a branch of the basilar), and brain vertigo ensuing.

A step further leads us to consider a sense of lassitude in the arm and forearm, as a reflex action from the meatus, when that canal contains a foreign body. Such a reflex is some-

times experienced, and the explanation is offered in that the impulse is produced on the auricular branch of the pneumogastric nerve, and conveyed by it to the pneumogastric centre in the medulla, then down the joint nerve to the cervical ganglia of the sympathetic, from which are given off the vaso-motors to the arteries of the upper extremities, and by these successive waves of irritation are received until finally the contractors yield to the dilators; arterial tonus thus suspended vascular engorgement and muscular weakness in these regions must follow. The most novel of these reflexes is one given by Dr. J. A. Musssbaumer, of Vienna, who affirms that he "produced in himself and brother the subjective perception of color by the objective perception of sound. The note 'small e' on the piano produces in the former the subjective perception of the color of dark yellow; in the latter the impression of dark blue."

Burnett, accepting this statement, supposes the cells of the auditory centre to be linked with those of the color centre.

The last point that space will permit me to take is "reflex ulceration in the external auditory canal," induced by irritation of the inferior dental nerve. Of all the aural reflexes this will prove most puzzling to the surgeon, if he fail to keep his anatomy before him.

Mr. A. B. presents himself to you with an ulcer of the external auditory canal, and you extend your examination to the mouth, when you are rewarded with finding several molars of a corresponding side in a state of decay. You apply to the ulcer an ointment of hyd. ox. flav. gr. ij., vaseline 3 i, and in a short time you pronounce him cured; but in a few days he returns complaining of a recurrence of the trouble, and you by the use of the same ointment heal it again and again as it would recur, until it was through the series; still it persists in its annoying presence until you order the decayed tooth to be extracted.

What can I offer in explanation of this neurosis?

As I have endeavored to explain the foregoing reflexes by tracing the nerve

connection between the ear and other parts of the economy, so will I attempt an explanation of this tissue change in the outer ear. Burnett says irritation proceeding from any part of the body may excite "waves of blood-vessel dilation in a correlated area."

To bring the idea more clearly before you I will take for example "herpes zoster," in which disease the site of the *primary inflammation* is in the spinal ganglia, the *corresponding area* is when the end organs of the spinal nerves that proceed from the point of irritation are distributed to the surface. Irritation in the cord causes inhibition of the vessels supplying the "correlated area," when waves of blood-vessel dilation, congestion, inflammation and vesication result. In ulceration of the meatus the site or irritation is in the inferior dental nerve, and the "correlated area" is in the meatus externus.

How may we establish the fact?

The vaso-motors (of the external carotid plexus) that control the blood vessels that supply the meatus (branches from external carotid) communicate with the sensory branch of the inferior maxillary division of the trifacial, from which the inferior dental nerve is divided, through the otic ganglion of the sympathetic. So irritation, proceeding, as it does, at the diseased tooth, is reflected to its corresponding area through the otic ganglion, the connecting link, mark you, between the inferior dental nerve and the vaso-motors that inhibit the calibre of the blood vessels that supply the meatus, causing the contractors of the latter nerves to yield to the dilators to the production of the same morbid changes that we finally have in herpes zoster.

## TREATMENT OF CHOREA.

BY SPENCER M. FREE, A.M., M.D.,  
OF BALTIMORE.

In a letter recently received from that venerable and careful practitioner, Dr. Hiram Corson, of Conshohocken, Pa., I find some observations of interest in speaking of chorea. He says, "I have never seen it associated with endo or



peri-carditis, or with rheumatism. I do not know one who has had chorea to have suffered from these affections, though a person, no doubt could have both these diseases at the same time, just as he could have a sore finger and chorea at the same time. Nothing could ever produce it in certain persons; not one in a thousand is likely to have it.

Persons of weak nervous system, and families with insane tendencies are liable to have it.

The *infusion of snake root* has always proved rapidly successful, save in a single case. I have thought that perhaps the drug was not, in that case, good or not properly administered. Three weeks ago a young friend took me to see a case in a girl thirteen or fourteen years old, I forget which. It is one of the most deplorable cases I ever saw, helpless in bed, with large bed-sores, pale as death and vomiting almost everything taken into the stomach. I advised the 'snake root.' They got the tincture or fluid extract. In about a week the doctor told me that she was no better. I told him to double or treble the dose if needful. Five days ago I again saw the doctor, who said she was getting well rapidly and was out of doors." This calls to mind a case which recently has been under my care. A girl aged fourteen. Third attack. Had been ill a long time with each of the former attacks. This had already been of eight weeks duration. No improvement, though treatment had been constant during that time. There was no lesion of the heart, functional or organic, nor had there been in former attacks. No rheumatism has existed at any time of life. Each attack was produced by fright, began at once as bilateral, and was severe from the start. Recognizing the advantage I had, in that the disease would soon terminate naturally, I thought to shorten the time by giving a pill of quiniæ sulph., arsenious acid, hydrarg. bichlor. and Vallet's mass. No improvement in a week; prescription was changed to the valerate of iron, quinia and zinc with arsenious acid and hydrarg. bichlor. This was tried faithfully, but the result was not

as satisfactorily as I wished. I then omitted the Vallet's mass, substituting for it the "snake root." Improvement began at once and rapidly continued until a fall down a flight of stair caused a relapse. The treatment was continued without change and the patient rapidly recovered. Whether all or any credit is due to the cimicifuga I cannot say, but the history of the case points considerably in that direction.

It has been recognized for many years. Trousseau is the only therapist of prominence who does not mention it in this connection. Hughes places it among the best remedies, especially where a rheumatic diathesis or complication exists, or where irregular or improper menstruation is present.

While on this subject of chorea I should like to call attention to a statement made by Dr. W. P. Shoemaker in the August number of the *Cleveland Medical Gazette*. He reports Dr. Stephen McKenzie as saying that not only do the majority of cases show heart murmurs during life, but that *all* cases show vegetations when dead. He also quotes a remark made by Dr. Sutton in answer to a question on the subject that "yes, all cases dead from chorea have shown heart vegetations."

This is so different from the observations of other pathologists that it deserves more than a passing notice.

### Abstracts and Extracts.

SOAP.—Dr. Henry Leffman, in the *Polyclinic* for August, 1886, says: Although the use of soap dates from a rather remote period, the chemist is still living, at an advanced age, to whom we are indebted for a knowledge of its composition and mode of formation. Considerably more than a generation has elapsed since Chevreul announced these facts, but a full appreciation of the principles involved is scarcely realized outside of the circle of professional chemists. Learned medical and physiological writers often speak of glycerin as the "sweet principle of fats," or term fats, compounds of fatty acids and

glycerin. Indeed, there is little doubt that the great popularity of glycerin as an emollient, arose from the view that it represented the essential base of the fats. With regard to soap, also, much erroneous and indistinct impression prevails. Its detergent action is sometimes supposed to be due to the free alkali, whereas a well-made soap is practically neutral.

A desire to secure either an increased detergent, cleaning, or other local effect has led in recent years to the introduction into soaps of a large number of substances, some of which have been chosen without much regard to their chemical relations to the soap itself. The result has been the enrichment of the materia medica with a collection of articles of which some are useful, and others worse than useless. The extension of the list of disinfectant and antiseptic agents and the increased importance of the agents, in surgery, have naturally suggested the plan of incorporating them with soaps, in which form they will be convenient for application. Accordingly, the circulars of the manufacturing pharmacists have prominently displayed the advantages of various disinfecting soaps.

Among these is a so-called corrosive sublimate soap, of which several brands are on sale. One of these, containing one per cent. of corrosive sublimate, is put on the market in cakes weighing about sixteen hundred grains, and each cake, therefore, contains sixteen grains of the drug,—a rather large quantity, perhaps, when it is remembered that four grains is a fatal dose. Fortunately, however, for the prevention of accidents, but unfortunately for the therapeutic value of the soap, a decomposition of the sublimate occurs as soon as it is incorporated in the soap mass, by which an insoluble mercurial soap is formed. This change takes place independently of the alkali used in the soap; in fact as mentioned above, a well-made soap contains no appreciable amount of free alkali, but is due to the action of the fat-acids. Corrosive sublimate is *incompatible* with any ordinary soap mass, and this incompatibility includes not only

other soluble mercurial salts, but also almost all the mineral antiseptics, such as zinc chloride, copper sulphate, iron salts. Some of the preparations of arsenic may, however, be incorporated with soap without decomposition.

Such being the chemical facts, we must admit that no reliance can be placed in corrosive sublimate soaps as germicide agents. It must not be supposed that this incompatibility interferes with the use of these soaps for general therapeutic purposes. It is only the specific germicide value which is destroyed. Since the fats used in soap manufacture yield oleic acid, we will have a certain amount of mercuric oleate formed together with stearates and others salts, and for purposes of inunction these salts might be efficient. Still, the physician would prefer, doubtless, to use the specially prepared mercurial.

In producing, therefore, a disinfecting soap, being debarred from using the metallic germicides, we are fortunate in the possession of a number of efficient agents, organic in character, which may be used without interference in soaps.

Among these are thymol, naphthol, oil of eucalyptus, carbolates, and salicylates. There is no chemical incompatibility of these with soap, and as they are somewhat less active, weight for weight, than corrosive sublimate, they are capable of use in larger quantities with less danger, and can thus be made equally efficacious.

It is in this direction, therefore, that we must look for the production of a safe and reliable antiseptic soap.

There is not much exact knowledge as to the usefulness of such additions to soap as borax and glycerin. They are frequently added, and highly spoken of in advertisements. Borax is a mild alkaline body, and as a detergent is probably equivalent to a slight excess of caustic soda. Glycerin, although originally considered an emollient, probably on account of its source and physical properties, is in reality, to some skins, a slight irritant. It is, in fact, an alcohol, not a fat. It does not pre-exist in fats, but is formed when the fat is decomposed by alkali or steam.



In ordinary cases, soap owes its detergent effect to a decomposition which occurs when it is put in water. A perfectly neutral soap, that is, one which contains the exact proportion of alkali and fat-acid, will, when placed in cold water, decompose into two portions, one containing an excess of the acid, the other an excess of alkali. The latter dissolves, and gives a slightly alkaline solution; the former precipitates, and gives peculiar turbidity constituting "suds." These reactions must be kept in mind in determining the effect of the addition of any special substance to the soap.

PROGRESS IN THE STUDY OF BACTERIOLOGY.—*The Lancet* says: "The progress made in the study of Bacteriology is one of the most remarkable facts of modern science. By far the greatest part of our knowledge respecting the nature of these protophytic organisms has been gained within the past decade, and even a shorter span of years embraces the period during which most of the microbes of disease have been discovered and investigated. Every year brings with it a fresh addition to the sum of knowledge upon the subject and already so much has been gained that the diffusion of such knowledge is taking place far beyond the limits of the laboratory and the physician's study. As an instance of this may be cited the extremely interesting volume which forms the latest addition to the series of International Scientific handbooks\*—a series that contains so much that is useful and that has a real educational value. M. Trouessart's work on Microbes, Ferments, and Moulds will do much to enlighten the reading public upon matters which not very long ago were considered as the somewhat precarious property of a few scientific enthusiasts. Bacteriology has a firmer footing now; and the publication of such a work as the recently issued collection of memoirs by Koch and colleagues by the New Sydenham Society has brought thus within the reach of the English

student many of the most important inquiries that have gone to strengthen the position and establish the value of this line of research. In this country, also, we have an increasing band of workers, who are adding important fact, and confirming statements already elsewhere made, and thus aiding in the sure but certain work of discovery of the nature of specific disease. The methods of research are comparatively simple, but from the very nature of the subject they require the exercise of the greatest skill and patience. It is not possible for everyone to be a bacteriologist. Life is too short to allow of the pursuit of such a subject to be carried on by those who are busied with the concerns of active professional work. Everything, therefore, which enables the bacteriologist to spread the knowledge of the facts he studies is of advantage, for it enables those who cannot, by force of circumstances, pursue this study in practice to at least comprehend the facts and their bearings in relation to disease. The application of photography is one of these methods, and its development in respect to microscopical work is in a fair way to be much advanced. Hitherto photomicrography has hardly come up to expectation. Theoretically its advantage over the pen and pencil sketch even when aided by the camera lucida should be great. To have a permanent reproduction of a microscopical specimen faithfully rendered, without any interpretation, should be a great gain; but the photographs have mostly been lacking in the sharpness of outline and clearness of detail which the specimen itself presents to the eye. Prof. Koch has long employed photography to render visible to others the forms of bacteria that are to be discovered in disease. We have now in this country the same work being undertaken, with every advantage of new processes, by such competent hands as those of Mr. Crookshank and Dr. H. Gibbes. Mr. Crookshank's large collection of photomicrographs has been exhibited at the Royal Society, the Microscopical and Pathological Societies, and on many other occasions, and has called forth

\*Published by Messrs. Kegan, Paul and Co.

well-deserved encomiums. They form at present part of the Photographic Exhibition at Glasgow, and Mr. Crookshank claims for them that they are taken from specimens irrespective of the staining reagent and mounting medium employed; and they are mostly taken with high powers, such as 1-25th in. objective, and even higher. Permanent autotypes, printed in various colors, facilitate the reproduction of the actual appearance of the specimens, and by enlarging from the original negatives a very considerable degree of magnification is attained. Both Mr. Crookshank and Dr. Gibbes deserve credit for showing what may be done by photography, and their work suggests a very useful extension of the process in anatomical and pathological investigations."

**TWO NEW TESTS FOR SUGAR.\***—The two reactions about to be described are common to cane-sugar, milk-sugar, glucose, levulose, and maltose, and to the carbohydrates and glucosides capable of yielding glucose by the action of sulphuric acid. They do not, however, produce any result with inosite, mannite, or quercite.

1. From one-half to two cubic centimetres of the suspected liquid are treated with two drops of a fifteen or twenty-per-cent. alcoholic solution of alpha-naphthol, and the mixture is shaken. A slight turbidity results from the precipitation of a little naphthol: sulphuric acid is then added in quantity equal to or even double the volume of the fluid, and the whole is briskly shaken. In the presence of sugar a deep violet color is developed, and dilution with water throws down a violet-blue precipitate, soluble in alcohol and ether with a yellow color, or in caustic potash with a golden-yellow color. In order that the reaction may occur as described, the test must be made exactly as stated.

This test will permit the detection of 0.00001 per cent. of sugar, and, with the exception of vanillin, anethol, methyl salicylate, and a few similar substances, gives no reaction when sugar is not

present. These substances, however, either produce the color with sulphuric acid alone, or the precipitate formed when the violet solution is diluted with water differs totally in character from that formed in saccharine liquids. The limit of sensibility of Fehling's test is 0.0008 per cent., and that of Trommer's test is 0.0025 per cent.

2. If, instead of the alpha-naphthol in the preceding test, an alcoholic solution of thymol of similar concentration be employed, the remaining manipulations being the same as before, a deep red varying from cinnabar to carmine is produced; dilution with water brings the color to carmine, and after a time there separates a flocculent precipitate, which dissolves with a pale-yellow color in alcohol, ether, and caustic potash, but with a bright yellow in ammonia.

The delicacy of this reaction is about the same as of that with alpha-naphthol. After many experiments had shown the trustworthiness of the results given by these tests, it was interesting, on account of their exceeding delicacy, to apply them to the solution of the disputed question whether normal human urine does or does not contain sugar. The results of the first attempts were so decided that the urine examined appeared to be diabetic. The urine of a number of perfectly healthy individuals was therefore examined, but with precisely the same results. The tests were made with alcoholic solutions of alpha-naphthol and thymol, exactly as has been described, and the extraordinary delicacy of the reactions can be better understood by the statement that normal urine diluted to from one hundred to three hundred times its volume with water still gives a recognizable reaction. When the urine is diluted to four hundred times its volume, the test shows no result.

In order that there might be no question as to sugar being the actual cause of the reaction, the following substances were examined and gave negative results with both alpha-naphthol and thymol: urea, creatine, xanthine, uric acid, allantoin, hippuric acid, succinic acid, phenol, pyrocatechin, and indican.

These results fully confirm the opinion advanced by Brücke, and supported by

\*From a communication to the "Kaiserliche Akademie der Wissenschaften," Vienna.



many other observers, that normal urine constantly contains sugar.

These tests may be applied in two different manners in order to distinguish a normal from a diabetic urine.

1. A specimen of normal urine and of that to be tested are equally diluted with water to about one hundred times their volume; the same quantity of each is then tested just as has been described; if the suspected urine gives a deeper violet than the normal specimen, it may be considered as diabetic.

2. The urine under examination is diluted with water to from four to six hundred times its volume. Even in this enormous dilution diabetic urine will sharply respond to the reactions of the tests described, while normal urine would give no result when diluted to four hundred times its volume.

After carefully studying the various tests for sugar in urine, F. Penzoldt came to the conclusion that the fermentation test is worthy of the greatest confidence in doubtful cases. All experiments, however, seem to show that the two new tests are decidedly more certain than the fermentation test. They leave but one thing to desire: they do not enable a distinction to be made between glucose and levulose, and although the sugar found in the urine will in nearly all cases be glucose, yet various instances have occurred in which levulose was detected also.—*Monatshefte für Chemie*.—*Phild. Med. Times*

SIR JOHN LUBBOCK ON THE STUDY OF SCIENCE.—The address delivered by Sir John Lubbock on the occasion of unveiling the statue of Sir Josiah Mason at Birmingham is reproduced in the current number of the *Contemporary Review*, and will be read with interest by all who are concerned in the promotion of the study of science. It is needless to say that the eloquent address of the member for the University of London was a masterly plea for the pre-eminence of science in the curriculum of a liberal education; and it is equally unnecessary to add that, while bestowing well-deserved praise on the labours and successes of his own university, Sir John Lub-

bock did not allow the opportunity to pass without girding at the universities of Oxford and Cambridge for their alleged neglect of science. Pointing to the facts recently embodied in a return to a motion he made in the House, Sir John stated that, of 240 schools, in 54 or over 20 per cent., no science whatever was taught; in 50 only one hour a week was devoted to science; in 76 two hours, or less than three; while out of the whole 240 schools only 6 devoted to the study of science as much as six hours a week. "In short, it is clear, therefore," contends Sir John Lubbock, "that, in spite of all which has been said, very little progress has been made in this respect. Our schools are generally more industrious; but, remarkable as it may appear, Latin and Greek absorb more time than ever." This is a state of matters which the leading "champion" of science in education, of course, very greatly deplotes. There may be differences of opinion on the comparative merits of the study of languages with all this contingently implies, and of the study of science, as agents in mind-culture; but as regards the main issue, there cannot, we venture to think, be any difference. All must feel the need of a better knowledge of scientific subjects, and desire to see the study of science extended. We do not, however, entertain the optimist views of Sir John Lubbock on the subject of science as a regenerator; nor do we share his opinion that "the study of natural history seems destined to replace the loss of what is *par excellence* termed 'sport,' engrained in us, as it is, by the operation of thousands of years during which man lived greatly on the produce of the chase." This is not a disposition of Destiny towards which we can look with yearning or even complacency. The race will never be ennobled, or the glory and independence of the nation increased and consolidated, by the development of a sentimental love of nature or of science. Englishmen must still love the gun and the chase, if they are to be robust as well as "learned." It would be a dark day for the land if the majority of the population should betake itself for past-

time to the study of science. It is well that there should be hobby-riders, or there would be no struggle for the pre-eminence of the several branches of enterprise, but, in all seriousness, the gentler arts must not be pushed to the neglect of the more *manly*.—*Lancet*, August 7th, 1886.

**TREATMENT OF STRICTURE OF THE URETHRA BY ELECTROLYSIS.**—It is to be regretted that the discussion on Dr. Steavenson and Mr. Bruce-Clarke's paper on the above subject at a recent meeting of the Royal Medical and Chirurgical Society should have taken place so late in the session, and to this and to the lateness of the hour must be attributed the paucity of speakers.

The subject is one of great interest. Six cases were brought forward which had been treated by this method, in none of which had recontraction taken place, though it must have been admitted that a sufficient interval had not elapsed to permit judgment to be passed as to the permanency of cure.

In the first case rigors occurred, but this can scarcely be wondered at when it is remembered that both gentlemen were employing this method for the first time.

We regret that more details were not given concerning the number, size, position and character of the strictures. We note also that, although no recontraction is said to have taken place, it does not appear that a thorough examination was made with a bougie à boule, without the aid of which slight constrictions are difficult to diagnose.

The *modus operandi* employed was as follows:

A gum-elastic or celluloid bougie with a wire running down to the centre terminating in a metal end, forms the electrode, this being connected with the negative pole is held gently pressed against the stricture, and should be of a size larger by 2 or 3 mm. than is the stricture's calibre. To the positive pole is attached a pad electrode which is placed over the sacrum, the patient lying upon it. The battery used is Stoehrer's 30 cell. A current strength

of from 5 to 8 milliampères is found requisite, which is gauged by means of a galvanometer.

In cases of eccentric stricture a funnelled electrode can be used, passed over a long catgut bougie which has previously been passed through the stricture, or filiform guide bougie may be passed, to which is screwed the electrode. By this means the electrode cannot fail to traverse the proper course.

After the passage of the electrode through the stricture, which may take from two to twenty minutes, the patient goes home and the urethra is left untouched for fourteen days. The treatment can then be repeated if necessary.

Speaking generally, from two to three applications are required.

In the discussion which followed, the writer of this brought forward a case of long-standing stricture where electrolysis had succeeded after treatment by dilation had failed. Although on commencing electrolysis the stricture only admitted a No. 4 bougie olivaire, after three applications a No. 28 passed. A month after the cessation of all treatment a careful examination of the urethra with a 22 bougie à boule failed to detect any trace of stricture.

Mr. Berkeley Hill complained of the want of details in recorded cases. He had tried electrolysis by means of a needle passed into the neoplastic tissue, the result being that the stricture got worse instead of better. Whatever good may have resulted from this plan of treatment he believed was due to dilatation by means of the electrode and not to electricity, and in this Mr. Buxton Browne agreed.

In the presence of the numerous cases now on record, we cannot but think that electrolysis is capable of causing strictures to disappear and probably of effecting a permanent cure. Much, however, must depend upon the way of carrying out the method. It appears that Mr. Fenwick has tried it in a good many cases at St. Peter's Hospital, but without much success. One reason of failure being that only weak currents were used and, working without a galvanometer, these were not accurately gauged.



Mr. B. Hill tried a method altogether different and failed; nor can this be wondered at, when one considers the plan he pursued.

In order to thoroughly investigate the electrical treatment of stricture it is necessary that cases of well marked organic stricture (and for preference those for which dilatation has been found to be ineffectual) should in the first place be submitted to some well-known surgeons, concerning whose powers of diagnosis there can be no question. These same men should at the expiration of treatment, and possibly again after the lapse of a year, examine and report on these test cases. It seems to us that only in some such way as this can this question be satisfactorily settled.

To further this object it is announced that at St. Peter's Hospital for Stone and Genito-Urinary diseases a special apartment is being instituted for the treatment of stricture by electrolysis, to the practice of which all medical men are invited.—F. SWINFORD EDWARDS, in *Annals of Surgery*.

**SYPHILITIC CHOREA.**—A young man in Buenos Ayres, who by his strange contortions had excited the curiosity of the passers-by, recently came under the care of Dr. Franceschi, who was somewhat puzzled by the symptoms. The movements were of a choreic nature, the most characteristic being a contortion of the thoracic abdominal and pelvic muscles. The patient's condition became so grave that he could not move out of his room. For a month various methods of treatment were unsuccessfully employed—electricity, sulphur baths, strychnine, hyoscyamine, &c. A consultation was then arranged with Drs. Valdes and Alcorta. The first of these gentlemen remembered having treated the patient six months previously for a chancre, which at the time was not thought to be syphilitic, and had not been treated by mercurials. There were no enlarged inguinal glands or other marks of syphilis; however, it was decided that the chorea might be of syphilitic origin, and therefore Ricord's pills (green iodide of

mercury), inunction over the spine of a mercurial and croton ointment, together with Van Swieten's solution (perchloride of mercury) and vinum ferri, were prescribed. In three days salivation occurred, and simultaneously with it the choreic convulsions disappeared. The mercurial treatment was then discontinued, but it was found necessary to resume it, for the convulsions soon began to recur. The salivation subsequently became so distressing that the mercury was again stopped, and the convulsions returned, though not so severely as before. Mercurial and iodide treatment was continued for six months, at the end of which time the patient was completely cured. Dr. Franceschi considers this case especially instructive, as, though various predisposing causes are usually named in connexion with chorea, neither syphilis nor mercurial treatment is mentioned, as far as he can find, by Bouchut, Graves, Jaccoud, Diday, Tardieu, or Trousseau. It has, on the contrary, been stated that mercurialisation may act as a factor in its etiology; here, however, is a case in which mercury cured it. The author seems to think that perhaps a hereditary syphilitic taint may sometimes have some effect on the development of chorea, and that, if so, mercury would be the best form of treatment to adopt.—*Lancet*.

### Society Reports.

#### PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING, HELD JUNE 25, 1886.

DR. AMY S. BARTON in the chair.

*Dr. Marie B. Weiner* read the following paper:

OPERATION FOR ABDOMINAL FISTULA AND REMOVAL OF GALL STONES.

Mrs. S.—Came to me in may 1883, to see what could be done for a fistula,

located about one inch below, and three-fourths of an inch to the right of the umbilicus. This had existed about two and a half years, remaining open and discharging a muco-purulent fluid. The history is as follows:

During October 1880, the patient, for the period of two weeks, had an attack of fever and although there were morning remissions and evening exacerbations it never left her entirely. This was accompanied by severe pain, particularly on the right side, which was best described as being similar to colic. There was also a general tenderness and her skin was compared, by her sister, to the color of old gold. After the attack passed off she enjoyed good health until sometime in the following January. Early in this month she lifted her mother, unaided, into bed, and a few days later, whilst walking along the street, slipped in such a manner as to throw her body backward, but did not fall. This accident was followed by a sudden pain in the abdomen. A "lump" formed, six or seven inches diagonally upward from the umbilicus, on the right side, about the size of a large fist, would partially disappear, at times, but never entirely. The whole side had a greenish-yellow discoloration, similar to that of a bruise, which gradually assumed a dark red color around the umbilicus.

Sometime in March, 1881, a small vesicle appeared a little below and to the right of the umbilicus, which the patient pricked with a needle. A thin liquid, mingled with some pus, escaped therefrom.

She poulticed it only at intervals, being somewhat undecided what was the proper course to pursue.

Finally allowing her physician to see it, he informed her that it was a fistula, and would have to be laid open; but this was never done, and the patient continued to try the various remedies prescribed, without the desired result. It would still continue to gather and break; and she soon learned that much comfort was derived if the track was kept open, to allow free drainage. At a later period, the date of which could not be recalled,

a small concretion, as large as a grape-seed, escaped from the opening, but it was not preserved. There was no life in the discharge.

When I first examined the patient, a bluish spot was seen, about the size of a ten cent silver coin, one inch below and three-fourths of an inch to the right of the umbilicus, somewhat raised above the surrounding tissue, an opening in the centre.

The probe entered four inches, with very little resistance and no pain, passing upward, to the right, and almost directly inward. It was thought an abscess had formed in the abdominal wall, for though questioned carefully she denied any jaundice until *after* the operation, and then too, for the first time, was any mention made of the small body like a grape-seed. Packing with oakum was first resorted to, without the desired result, then injections, of almost all the irritating liquids at command, in such cases, were used; but the fistula continued open.

An operation was strongly opposed by the patient and since no other benefit had been derived from the treatment, except comfort, it seemed as though the only course was to continue the injections.

I succeeded in obtaining a consultation with Prof. W. W. Keen; who during the examination succeeded in introducing the probe six inches, it seeming to take a more direct course posteriorly. Prof. Keen advised an exploratory incision, which was made May 1st, 1884. At 2 P. M. on that date, the patient being etherized, a probe was inserted and its dissection determined by counter-pressure. An incision was made diagonally over the probe, in the direction of the liver, about four inches in length dividing, successively, the integument, subcutaneous fat, and muscular tissue. The fistulous tract was thus laid open, and I was enabled to insert the probe two inches farther, when it struck a resisting body, suggesting a bone, or more likely a calculus; I then dilated the canal with a pair of hæmostatic forceps, and as this was done a small calculus fell between the blades, and lodging there, was withdrawn with the instrument. The character



of the fistula was now determined. A small rent in the fascia beneath the transversalis muscle, made by the procedure of stretching, was brought together by three catgut sutures; the remaining stones were then removed, numbering, in all, eleven; they were whitish in color, round in shape, not faceted; the largest was about the size of a hickory-nut, and the smallest was about as large as the head of an ordinary black toilet pin. Careful search for more proved fruitless, though both probe and finger were used. An attempt was made to determine whether the cavity, at the internal end of the fistula was the gall bladder or a false cavity, but no positive conclusion was reached. The cystic duct could not be found.

The wound was washed out carefully with a stream of carbolized water (5 per cent.), a large drainage tube inserted the length of the tract, the parts brought together by seven wire sutures, and dressed with antiseptic dressings. The patient was permitted to get up for half an hour on May 14th, just two weeks after the operation, and from that time gained strength steadily. During her confinement to bed her temperature fluctuated between 98.4° and 101°, reaching the higher point but few times during her illness.

For the first few days there were severe nausea and vomiting, which were controlled by the administration of brandy and aromatic spirits of ammonia.

The wound was dressed the day after the operation, the bandages being soiled with blood. On the fourth day after the operation the discharge became purulent, and so continued.

On June 11th, the patient visited Dr. Keen at his office; the drainage tube had in the meantime been changed to one of smaller calibre, but of the same length as the one first introduced. The discharge was still free and of a mucopurulent character. Dr. Keen suggested daily injections of a solution of gtt. xl tincture ferri chlor. to f̄j of water, and to shorten the drainage tube. This was done with the view of determining if a communication existed between the

tract and the duodenum. The injections were continued for ten days, but with no dark discoloration to the fæces. The discharges were, however, materially lessened, and I again shortened the drainage tube, leaving only about 1½ inches. I then began using injections of argent nit. gr. xv to ʒj, every other day, with continued improvement.

During the period of twenty-four months there have been two profuse discharges of pus from the tract; the exact amount discharged unknown; these were preceded by great pain, radiating about the right side and between the shoulder-blades. After the last discharge of pus I was able to insert the probe 6½ inches, passing slightly upwards and almost directly inwards, producing sharp pain, which caused the patient to gasp. The patient is in no better condition since being operated upon than she was previously.

She will cheerfully submit to a second operation, *provided* a reasonable prospect of recovery can be held out to her.

MARY WILLITS, M.D.,

Recording Secretary.

## OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, SEPT. 2, 1886.

The President, B. F. BAER, M.D., in the chair.

### INTUBATION OF THE LARYNX.

*Dr. E. E. Montgomery* exhibited a set of Dr. O'Dwyer's tubes, the gag, and the instruments for the insertion and removal of the tubes. He related the history of a case of laryngeal diphtheria in which they were successfully used to relieve asphyxia. In consequence of an over dose of stimulant the tube was coughed out and had to be replaced as the child could not have breathed without it. The doctor contrasted the difficulties of tracheotomy with the comparative ease of introduction of the tubes, and called attention to the want of success attending the former

operation as parents will not give an early consent for its performance. He had performed eleven tracheotomies before he had a single successful case, and as his first intubation case has been a success he feels strongly in favor of the new operation.

#### REMOVAL OF THE OVARIES FOR UTERINE FIBROID.

*Dr. M. Price.* The case is one of interstitial uterine fibroid, the uterus being about the size of one at the third month of pregnancy, irregular in outline and nodular and pelvic bound. The ovaries were displaced backward and incarcerated between the uterus and sacrum, making it difficult to remove them. The woman had been suffering four years, and a confirmed invalid during the last one, unable to do any work. Her marital relations had been suspended for over a year, owing to the sickening pain attending any attempt at sexual intercourse. She had to walk with great care, and lie on her stomach while resting or sleeping to prevent a throbbing and sickening pain in the pelvis. Another exceptional and interesting feature of the case was the absence of profuse and irregular bleeding. Her menses were irregular, scant and pale. Her chief suffering was from engorgement of and pressure upon the ovaries. All kinds of treatment had been persevered in for the last three years, and the patient grew worse. She demanded operative procedure for her relief, preferring the risk of death to her suffering. The ovaries were removed, July 9, 1886. They were hypertrophied. They were found low down behind the uterus. They contained numerous pus pockets. The tubes were enlarged, but did not contain pus. With the exception of a suture abscess she did perfectly well and made a perfect recovery. She is now able to look after her domestic affairs, and is free from pelvic pain and soreness.

No examination of the condition of the uterus has been made since the operation.

#### Correspondence.

BALTIMORE, Sept. 6, 1886.

*To the Ed. Maryland Medical Journal:*

DEAR SIR: While in Washington recently, I visited several times "The Toner Collection," now forming part of the Congressional Library, and in the hope that the pleasure and profit I derived from it may induce others to follow my example, I desire to call attention to the value of Dr. Toner's contribution to the literary treasures of our profession.

The doctor has for many years, as is well known, devoted his means and leisure to the purchase and preservation of our early American medical literature, chiefly, though not wholly, confined to the collection of works issued before 1800.

In 1882, with a liberality which did him great credit, and put his *confreres* under lasting obligations, he donated the entire collection (to which he is still making additions) to the Congressional Library, where it is open to every member of our profession, and, indeed, to every citizen who has a literary, historical, or antiquarian taste to gratify.

The library of the Surgeon-General's office, collected and arranged by the zeal and industry of Dr. J. S. Billings, forming, as it is acknowledged to do, one of the most, if not *the* most, complete working medical libraries in the world, supplemented by this special collection of Dr. Jos. M. Toner, renders Washington, the national centre of our medical literature, and a place of peculiar attractiveness to the professional student.

I regret to say, however, that the full extent of "Toner's Collection" can hardly be realized now by a casual visitor, owing not only to the fact that a portion of it is under the hands of the cataloguer and binder, but also because of the limited space which the necessities of the present building allot to it. It is scattered in several different apartments and on different floors, which, of course, detracts from a proper display of its extent and variety; and but for the kind assistance of Dr. Toner and the em-



ployes of the Congressional Library, interferes seriously with its ready accessibility.

The defects of the present building and the consequent confusion of the books for want of sufficient room, have long been a matter of complaint, but, thanks to the persistent efforts of A. R. Spofford, the efficient librarian, Congress has at last recognized its duty, and the necessary legislation has been made for a new and more commodious structure, and we are pleased to find him in his report for 1884 enforce on the attention of Congress the fact, that "this collection" (Toner's) "needs wider and more accessible space for its arrangement and preservation," and I feel that I voice the hope of the medical profession throughout the Union when I say that justice to the donor, as well as the utility of the collection to us, demand ample provision in the plan of the new National Library Building for the full display, easy accessibility and convenient use of Dr. Toner's valuable gift.

"Toner's Collection" embraces medical and historical books, which, according to the report of the Librarian for 1885 (before me,) number 28,116 vols. of books, and 18,000 pamphlets, and with the additions since made, make a total of 28,299 of the former, and 18,615 of the latter. Besides these it comprises some 1,500 portraits of medical men, and 3,000 to 4,000 medical biographies in MS. and some 1,500 in print, all arranged for easy reference, in alphabetical order. There are also check lists (similarly arranged) affording references to more than 20,000 physicians. The monographs, &c., on yellow fever, small-pox, vaccination, and epidemic diseases, are very rich and complete."

When it is recollected that all this information has been gathered at considerable expense, and by years of patient toil and plodding, persevering search through medical journals, biographical dictionaries, encyclopædias, newspapers, private correspondence, &c., &c., the immensity of the labor will be appreciated by those, at least, who have delved for 'hidden ore' in historical veins. Such a labor of love richly earns

the gratitude of the whole American profession, and when I looked on this noble monument to the liberality of the donor and to the perpetuation of the fame of my medical ancestry, I thought with old Burton, "how much are all we bound to these illustrious Ptolemies, bountiful Mæcenases—'*Qui nobis pace otio fecerunt*'—that have provided for us these well furnished libraries, where among so many divine souls I can take my seat, with such sweet content, that I pity all our great ones and rich men that know not this happiness."

Yours truly,

JOHN R. QUINAN, M.D.

DISCUSSION ON OVARIOTOMY.—The discussion concerning ovariectomy has now been going on for some months. Many of Mr. Lawson Tait's detractors are not slow to suggest that by his eager advocacy of the operation he has induced many surgeons to perform it in unsuitable cases, even if he has not done so himself. Mr. Tait's rejoinder is that he has frequently protested against the indiscriminate removal of the uterine appendages without due consideration. The Liverpool inquiry has not yet come off, and the whole subject may be regarded as in an unsatisfactory state. In evidence of this the following incident recently narrated on good authority may be recounted: A lady coming from abroad was advised to consult a certain distinguished surgeon who diagnosed disease of the uterine appendages and recommended their removal. By the wish of her friends she consulted a well-known gynecologist before consenting to the operation. He carefully examined her and then delivered himself to the following effect: "Yes, you may have your ovaries removed, and may be it will do you good. And you may have your great toe removed, and perhaps that would do you good. Of the two, perhaps the latter will do you the most good." The patient, however, in spite of this opinion visited the first consultant again, had the operation performed, and then left this country.—*London Correspondence.*

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, SEPTEMBER 11, 1886.

**Editorial.**

THE LEGAL ASPECT OF REMOVAL OF THE UTERINE APPENDAGES.—A case of important medico-legal bearings has recently been tried and decided in Liverpool. The facts involved in the case have reference to the legal right of the surgeon to remove the uterine appendages without the knowledge of the patient. The verdict of the jury in this case practically justifies the surgeon in the performance of the operation when, in his judgment, it is clearly indicated.

The facts are as follows: John Casey, a laborer, and his wife Mary, instituted suit against Dr. Francis Imlach, one of the senior surgeons of the Hospital for Women, Shaw street, Liverpool. The action was brought to recover damages from the surgeon for performing improperly an operation upon the female plaintiff, without her consent.

The plaintiff, Mrs. Casey, stated that she was forty years of age, the mother of five children and had borne fair health up to the time of the operation in December, 1884. In March, 1881, she began to suffer with pain in the lower part of the abdomen, for which she was treated and cured. In April, 1883, she had another attack and was cured. She remained well until December, 1884, when she felt a similar pain in her abdomen. She went to the defendant on December 8th, and told him about this, and he then examined her. He told her she would have to be operated on, as she was suffering from inflammation outside of the

womb. On December 15th, she entered the hospital, and was operated upon on the 18th. She claimed that she was not told by the defendant or anyone in the hospital what the result of the operation would be. Ten weeks subsequent to the operation she went to the defendant and told him she had not been "unwell," and was then informed for the first time that her ovaries had been removed. She considered her health to have been worse since the operation than it was before, and between herself and her husband it had made a wonderful change.

Dr. Imlach, the defendant, denied the allegations made by the plaintiff as to her ignorance of the character of the operation and its results. He affirmed that the woman came to him suffering with severe and irregular loss of blood. His first examination disclosed a serious state of the woman's health and he considered an operation imperatively demanded. He found the ovaries sclerotic and the tubes in a state of inflammation. The uterus was dragged from its position, retroverted, restricted in mobility, and bound by adhesions. When he opened the abdominal cavity he found coagulated blood in the pelvic cavity due to intra-peritoneal hæmatocoele. The right tube was thickened and dense and adhering to the pelvic walls. The ovaries were contracted like the hard kernel of a hazel-nut. He was certain it was a case of hopeless sterility. The presence of the tubes he considered dangerous to life if left as they were. He had no reason to suppose the sclerotic ovaries were dangerous to her life, but if they had have been healthy and the tubes as he had described, there would have been no advantage in leaving the ovaries.

A considerable amount of expert testimony was introduced by both the plaintiff and defendant, and the evidence offered in regard to the advisability of the operation of removal of the uterine appendages was conflicting and indefinite. Statements were made by expert witnesses on both sides which do not seem to us to accord with the facts.

There seems to be no room for doubt as to the value of the operation in



question when performed in properly selected cases, but it cannot be denied, we think, that the operation of spaying is now being performed too indiscriminately and unjustifiably. There is just at present a popular craze on this subject and ovaries are being sacrificed in a wholesale manner. As an evidence of this tendency one of the witnesses, Dr. Grimsdale, recited the fact that in the Liverpool Hospital for Women, 111 women were spayed during the past year and 44 during the previous year.

Mr. Lawson Tait stated that, including abdominal sections, he had operated about 1600 times. Mr. Tait also asserted that intra-peritoneal hæmatocele was fatal in 96 per cent. of the cases if left too long. In the great majority of cases it was fatal in three hours, and the longest time he had known before it was fatal in one attack was forty eight hours. Such sweeping assertions do not seem to us to be justified by the facts, and the judge very properly corrected Mr. Tait's statement by the remark that "This woman had three previous attacks, and none of them were fatal, although treated medicinally and not surgically." Mr. Tait's quick retort, "This is a case that is unique and I have seen none like it," does not seem to us to sustain his strong assertion.

The question of loss of sexual desire after spaying was an important issue in the case. The plaintiff asserted that the passion had been destroyed by the operation and that it had made a difference between her husband and herself. The evidence of such observers as Savage, Aveling and Tait disputed this fact. These witnesses believed that removal of the ovaries had no detrimental effects whatever as regarded sexual desire. Dr. Aveling cited the fact that in the case of eunuchs the sexual desire was not removed.

Mr. Savage said in a number of cases the removal of the ovaries increased the sexual desire. The evidence tended to show that there is no general law applicable to all women who have been spayed. One woman may lose all sexual instinct, and another may experience an increase of the sexual desire.

It will be admitted that there is often a strong tendency upon the part of both patients and physicians to run to extremes. Many women would cheerfully sacrifice their ovaries to escape irregularities of menstruation; others would undergo the ordeal of spaying to escape childbearing; upon the part of a few the desire for increased sexual passion might be a determining motive, were this fact known and believed to be true. Hence we see that a procedure of undoubted value in properly selected cases is open to grave abuse, and it is important that the present tendency to spaying should be kept in check by those who practice abdominal surgery. At the close of the evidence in the above case his Lordship was about to adjourn, when the jury intimated that they had made up their minds about the case and were ready with a verdict. Counsel in the case agreed to accept the decision of the jury, who then returned a verdict for the defendant.

The burden of evidence in this case clearly proved that Dr. Imlach was justifiable in removing the ovaries and tubes in the case in question. The chief point raised was whether he should have operated without the patient's knowledge and consent and without explaining to her the results of the procedure. Dr. Imlach asserted that the patient was fully advised in regard to her future condition, whilst the plaintiff stoutly denied her knowledge of the effects of the procedure. The verdict of the jury fully exonerated the defendant.

### Miscellany.

RENAL IRRITATION FROM PURE TEREBENE.—A correspondent writes to the *British Medical Journal* to ask his professional brethren whether they have ever noticed severe nephralgia and other evidences of renal irritation follow the use of "pure terebene." He has lately had under his care a case of bronchiectasis, in which he tried all the stock remedies, such as creasote, eucalyptol, iodine, phenol, iodoform, tar, sandalwood oil, and, lastly, "pure terebene," to try and diminish the secretion and les-

sen the almost gangrenous odor of the sputa. He thinks he may safely say that they all practically failed to accomplish what he intended, even though the doses were pushed. "Pure terebene" was the last experimented with, and when his patient was taking from twenty to twenty-five minims four or five times during the twenty-four hours, he suddenly developed most intense nephralgia, and the urine became scanty, high-colored, and distinctly albuminous. There had been traces of albumen before, but it was distinctly increased at this. There was no reason to suspect renal "colic" due to other causes. The terebene was omitted, and gradually the symptoms subsided. After the lapse of three weeks, "pure terebene" was again begun to be taken, and, as the doses were increased to the same quantity as before, a repetition of the nephralgic symptoms occurred, but less marked than before, and gradually a tolerance was established. Ordinary turpentine, it is well known, will produce symptoms of renal irritation; may it not be possible that its isomeric brother, "pure terebene," also will occasionally produce somewhat similar symptoms?

**PERIPHERAL NEURITIS AND TABES.**—The interesting fact that tabes dorsalis is often associated with, and even preceded by, lesions of a peripheral rather than a central kind has attracted much attention of late. We have before mentioned the contribution made by M. Pierret to the Academy of Medicine, and we may now add the conclusions arrived at by M.M. Pitres and Vaillard from a study of many cases (*Rev. de Méd.*, July, 1886). These statements are to the effect that the peripheral nerves of tabetic subjects are often the seat of indubitable inflammatory changes in no way differing from other forms known as non-traumatic neuritis. The changes are very variable in their situation; the sensory, mixed, and visceral nerves may be attacked. In the majority of cases, but not in all, the neuritis begins at the terminal extremities of the nerves. The extent and gravity of the changes bear no constant relation to the age, extent,

or depth of the spinal lesions of locomotor ataxy; nor do they apparently take any share in the special symptomatology of tabes, as the lightning pains, motor incoördination, abolition of knee-jerk, and disorder of muscular sense—symptoms which seem to be due to the sclerosis of the posterior columns and the posterior nerve roots. On the other hand, there are certain rarer symptoms which seem to be directly related to peripheral neuritis; such are (a) areas of cutaneous anæsthesia or analgesia; (b) tropic skin lesions, as perforating ulcer, œdema, eruptions, dystrophy of the nails; (c) certain motor paralyses, accompanied or not by muscular atrophy; (d) arthropathies and spontaneous fractures; and in some cases the visceral neuralgiæ may be attributed to neuritis of the corresponding nerves.—*Lancet*, Aug. 7, 1886.

**A NEW METHOD FOR THE RESTORATION OF RESPIRATION LOST UNDER CHLOROFORM.**—Dr. R. Milne Murray describes a new method for the restoration of respiration lost under chloroform, which he terms "perflation," as follows:

"Disconnecting the rubber tubing, I take the end of the branch with my finger, and make one or two aspirations of the lungs, compressing the chest gently at the same time. This removes a considerable quantity of vapor from the upper passages. Then, opening the branch, I make a series of deep inspirations.

"The air rushes in by the branch, and no doubt the greater part passes into the mouth; yet some of it enters the lungs, and a current is thus established by which a very large quantity of the chloroform is rapidly expelled, as can be proved by the taste of the air coming through the tube. After two or three such inspirations, the taste of the vapor becomes fainter, and as soon as this is noticed, I reverse the process, now blowing air into the tube, with force just sufficient to cause the chest-wall to move in the slightest possible degree—the branch tube being open all the time. Generally, after one or two such perflations, the heart shows signs of vigorous



action, and shortly thereafter breathing commences, and continues in a perfectly natural manner. Should it not return so rapidly, and after I am assured by the absence of taste or smell in the expired air that the chloroform has been almost entirely removed, then I close the branch tube, and commence gentle inflation of the lungs in the ordinary way.

"Speaking broadly, as regards the difficulty of resuscitation as indicated by the time required to effect it, I have observed that *the time required to restore respiration varies inversely as the concentration of the dose, and directly as the time required to stop respiration*—in other words, the more concentrated the dose the easier was the reanimation, and the longer respiration continued under the action of the vapor the more difficult was the reanimation."—*Edinburgh Med. Jour.*

**SUICIDES AMONG CHILDREN.**—There can be no question that there has of late years been an increasing proportion of suicides among children, or very young persons. No psychical reason exists why this should not be so if the brain is very early put to hard labour, but it is unfortunate when an organ incompletely developed is thus severely strained. The practical question is whether there may not be something in our mode of training the young which "forces" the brain unduly. Moreover, is there not a tendency to place children too soon in the career of life in a position calculated to strain and worry them?—*Lancet.*

**APPLICATION FOR USE IN THE ERUPTION OF WISDOM TEETH.**—Delieux de Saignac has commended the following mixture as an application to the inflamed gums over wisdom teeth in the process of eruption:

Glycerole of starch . . .	3ij
Pulverized borax . . .	gr. xv.
Pulverized saffron . . .	gr. viij.
Tincture of myrrh . . .	gtt. x.

With this make gentle and repeated frictions of the gums.—*Revue de Thérapeutique*, July 15, 1886.—*Med. News.*

**THE TREATMENT OF PARONYCHIA.**—Dr. Sellden writes in the *Eira* that he has for years made a special study of this subject. The greater number of his patients have been miners, smiths, machine laborers, servants, and others whose fingers are exposed to injury. The disease commences in the subcutaneous tissue, and spreads to the periosteum. There are differences of opinion as to the varieties of this disease, some authors asserting that there are four others that there are only two—the deep and the superficial inflammation. Dr. Sellden, after a series of trials, found the following method most efficacious in the treatment of paronychia. When the patient will consent to incision, the finger, after it had been opened, is instantly plunged in a tumblerful of hot water, which is then allowed to cool till it is nearly lukewarm. Half a teaspoonful of arnica is poured in, and a teaspoonful of the usual 10 per cent. solution is added. This mixture is highly anæsthetic; the finger is held in it for fifteen minutes, when the "bad matter" comes out. This expression is very characteristic of the phenomenon. The blood and pus exude in a thin stream about the size of a knitting needle, which forms circles in the alkaline liquid, and finally settles in a thick mass at the bottom of the glass. Fifteen minutes or a half an hour after the finger is dried it is rubbed with vaseline ointment containing 10 per cent. of sulphide of potassium. The finger is then immediately enveloped in a poultice which continues warm till the next finger bath, and thus hastens the cure. These finger baths are taken from two to four times daily, and the wound is covered during the earlier days with sulphur ointment, and later with a boracic ointment. The finger is then bound up with a wadding compress and a bandage. Carbolic acid may be used in the finger bath, but Dr. Sellden gives the preference to arnica, which he finds particularly useful in all sorts of injuries.—*Lancet*, Aug. 28.

**A CONTRIBUTION TO THE KNOWLEDGE OF THE ACTION OF URETHAN.**—Dr. E. Braun, being a sufferer from insomnia

caused by heart disease, tried the action of urethan, and contributes his experience of this drug to the *Eira*. The first evening he took a dose of two grammes, hoping confidently to fall asleep in "from ten to thirty-five minutes." In this hope he was disappointed, as, instead of sleeping, he lay in a peculiar sort of trance, conscious of all that went on round him, hearing the striking of the clocks both at the hours and half-hours, and the voices of people in the street. The following evening he again took two grammes at 11 o'clock, and, as sleep did not follow, he took another gramme in an hour's time; the same peculiar condition occurred. The third evening Dr. Braun took three grammes at a time, but without any other result. He now gave up the experiment, as he was aware that large doses were not considered advisable. About a day or half day later he suffered from difficulty and pain in passing urine, and found on examination that there were traces of albumen. Some hours later he had fever and a severe headache. The symptoms all vanished after forty-eight hours, with the exception of the difficulty in passing urine, which lasted for several days. Dr. Braun judges, from his own experience, that immunity from after-effects with urethan is not so certain as has been stated.—*Lancet*, Aug. 28.

**SAFETY OF COCAINE IN CATARACT EXTRACTIONS.**—Dr. C. E. Frothingham presents in the *Journal of the American Medical Association*, (August 21, 1886), an account of thirty-nine cases of cataract extraction in which cocaine was employed, and deduces from his experience the following conclusions:

1. Cocaine relieves the operator from the embarrassments during the operation for cataract that arise from vomiting, also from the agitation of his patient which results from excessive bronchial secretion or stertorous breathing. These are often very troublesome when ether or chloroform is used.

2. The danger to the result which often arises from nausea and vomiting after the extraction, when other anæsthetics are employed, is very surely

avoided when cocaine is selected as the anæsthetic agent and is properly used.

3. The danger arising from the depressing effect of cocaine upon the nutrition of the cornea is no greater than in cases where ether or chloroform is used. The depression of the circulation which often arises from either of them, may affect very injuriously the corneal nutrition.

4. The disturbance of the circulation of the interior of the eye, and consequent danger of panophthalmitis from this cause, is probably less in using cocaine for this operation than in resorting to general anæsthesia.

5. The danger of sepsis and consequent panophthalmitis from the use of cocaine may be avoided by using only fresh solutions.

**MEDICAL STUDENTS IN SWISS UNIVERSITIES.**—The number of the medical students in Switzerland appears to be increasing. During the present summer session the total is 675, including 81 women, who are admitted in Berne, Geneva, Zurich, and the preparatory school of Lausanne, but not in Basle. In Berne there are no less than 40 female students; some of the assistants' posts are filled by women. It is remarked that their exercises, or degrees are usually selected from theoretical subjects—such as anatomy, and pharmacology—rather than from practical medicine and surgery. The increase in the number of students is due almost entirely to an accession from Switzerland itself, the number of foreigners (192) being much the same as in former years. Of the 81 female students, only 10 are of Swiss nationality.—*Med. News*.

**ANTIPYRINE IN PEDIATRICS.**—In the policlinique of Rio Janeiro, Professor Moncorvo has tested the value of antipyrine in infantile therapeutics by administering it to more than one hundred children of various ages, the youngest being only thirteen days old. The principal diseases treated were bronchitis, broncho-pneumonia, tuberculosis, acute rheumatism, and some surgical affections associated with suppurative



fever. As much as from two to three grammes of the agent were given every hour or two, and repetition regulated by half-hour thermometric observation. No toxic effect was observed, and defervescence was rapid and regular. Antipyrene may be employed hypodermically, and when administered by the mouth may be combined with quinine, the absorption of which it appears to facilitate.—*Lancet*, Aug. 19.

THE OUTLOOK FOR THE CONGRESS.—Professor W. F. Peck, of the Iowa State Medical University, who is now making an extended tour of Europe, writes as follows from Amsterdam to the *Journal of the American Medical Association*: "I visited Professor Esmarch the other day in Kiel. He will come to the International Medical Congress. From what I can learn the profession of Europe will send a large delegation. Professor Billroth told me that he expected to attend, and Carl Braun will accompany him."

ECZEMA OF THE SCALP.—Borax, says Deligny (*LEczema*, Paris, 1885) is the best application in scaly eczema of the scalp, not only in cleansing the head, but in arresting the desquamation. Michele recommends:

R. Sodii biborat., gr. cl.  
Alcoholis,  
Aquæ rosæ, aa f 3 iv. M.

Boric vaseline is an excellent preparation which is often employed at the St. Louis Hospital:

R. Pulv. acid. boric., 3 iss.  
Vasellini, 5j.  
Bals. Peruv., gr., viij., M.

Besnier applies two or three folds of thin muslin wet with starch water, a teaspoonful to the quart of water, and covers this with a rubber cloth in crusted eczema of the scalp. If there is fœtor, he adds seventy-five grains of boric acid to the quart of water. When all inflammation has disappeared, he recommends the addition of fifteen grains of sulphate of copper to the quart of water, to be used with discretion.—*Medical Times*.

THE SURGERY OF THE LIVER.—At the recent meeting of the British Medical Association, Mr. Lawson Tait read a paper before the Surgical Section in which he gave the statistics of fifty laparotomies undertaken for disease of the liver or of the gall-bladder. They included 7 exploratory incisions, with 1 death; 13 hepatotomies, with no death; and 30 cholecystomies, with three deaths, 2 of the latter being from the subsequent progress of cancer of the liver.—*N. Y. Medical Journal*.

CRUSHING THE GRANULATIONS IN TRACHOMA.—Dr. Kramsztyk, writing in the *Gazeta Lekarski*, advises a method of treating granular lids or trachoma which was proposed by Dr. Wicherkiewicz, and which consists of a forcible crushing of the granulations. The eyelid is everted and held by an assistant, and is then subjected to pressure between the two thumb-nails, the operator moving his thumbs to and fro so as to act on as much of the eyelid as possible. Where the granulations cannot be reached in this way, such as those situated at the canthi and on the plica semilunaris, they are pricked with a needle, and then crushed by means of a pair of forceps or some other suitable instrument. The operation is very painful, and cocaine seems to be of little use. Under chloroform, the whole of the granulations can be crushed at a single sitting. Otherwise the length of time and the number of sittings required to effect a cure depend on the abundance of the granulations and the patient's power of endurance. Where other disease of the conjunctiva exists, it must of course be attended to, and different measures adopted. The after-treatment consists in the prolonged application of cold water dressings to the eye.—*Lancet*, Aug. 14th, 1886.

### Medical Items.

The death, at the age of forty-four, is announced of Dr. Hermann Maas, Professor of Surgery in Würzburg.

The English Congress of Hygiene will be held at York in September, under the presidency of Sir Spencer Wells.

It is stated that after the beginning of next year, the vacation courses of the Vienna Medical Faculty will be discontinued.

The Emperor of Russia has sent 40,000 roubles to the Pasteur Institute, the total subscriptions to which now amount to £64,000.

Prof. Arlt, the renowned ophthalmologist of Vienna, is said to be suffering from gangrenous thrombosis of the leg.

Politzer says, "no one should operate on the living before having performed the operation at least forty or fifty times on the dead."

The *St. Louis Weekly Medical Review* says that Chicago maintains six medical societies, seven medical colleges, and eight medical journals.

Mr. George Lawson, F.R.C.S., has been appointed Surgeon-Oculist in Ordinary to Her Majesty, in the place of Mr. W. White Cooper deceased.

Eighteen hundred and twenty persons have committed suicide within the last eight years at Monte Carlo, the great gambling establishment belonging to the Prince of Monaco.

The fifty-ninth reunion of German naturalists and physicians will be held in Berlin from the 18th to 24th of September. A cordial invitation has been issued to those interested in all countries.

The number of students in the Imperial University at Tokio is said to be nearly one thousand, a large portion of which are students of medicine. Five of the professors in the medical faculty are Germans.—*Med. Record*.

A member of the medical profession has published a fee list, in which he estimates the value of his services at the rate of \$500 for a non-septic dressing, while a dressing in septic cases is made at the comparatively cheap price of \$25.—*Med. Record*

The *Lancet* says: A gratuity of £100,000 has been granted from the Bavarian Civil List to the widow of Professor Guden of Munich, who perished with the late King of Bavaria in the lake at Castle Berg. He left a family of eleven children.

The American Dermatological Association has elected the following officers for the ensuing year: President, Dr. H. G. Piffard, of New York; Vice-Presidents, Dr. F. B. Greenough, of Boston, and Dr. R. B. Morison, of Baltimore; Secretary, Dr. G. H. Tilden, of Boston; Treasurer, Dr. Le Grand N. Denslow, of St. Paul.

Herr Paul v. Ritter, of Basle, has signified his intention of leaving 300,000 marks to the University of Jena, for the purpose of promoting the study of philogenetic zoology according to the Darwinian theory. He will give

130,000 marks at once, and the balance will be paid after his death. Professor Haeckel, of Jena, an enthusiastic teacher of evolution, proposes to use the gift for the establishment of a professorship of zoology to be called, after the donor, the Paul v. Ritter Chair of Zoology.

We understand that the Commission appointed to inquire into the results of M. Pasteur's inoculations, have prepared a draft report, but that they withhold it until they can ascertain the accuracy of the reports of fatal cases which have recently been published. The experiments conducted by Mr. Victor Horsley have, we learn, so far fully confirmed M. Pasteur's statements; but they are not yet complete, and will therefore be left to be detailed in the report.—*Lancet*.

Dr. Wm. M. Kemp, one of the oldest and most favorably known physicians, of this city, died at his residence, No 75 North Greene street, on September 6th, after a protracted illness. Dr. Kemp was born in Frederick County, Maryland. He located in this city in 1839, and during his long residence here has been an active and untiring worker in his profession. He filled a number of positions of trust and in the discharge of all of his duties has exhibited zeal and loyalty. He has been an active worker in the Lutheran church, of which he was a member, and for some years has been superintendent of St. Mark's Lutheran Sunday school. This duty he continued to perform whilst engaged in a large general practice of his profession.

Dr. Kemp has enjoyed to an eminent degree the respect and confidence of all who knew him, and his death will be much lamented.

We hope to be able to publish a fuller notice of the life of this highly respected physician in a subsequent issue.

During a recent visit to Danville, Ky., the writer had the privilege of examining the house in which Dr. Ephriam McDowell, the father of ovariectomy, lived. The building, a two story wooden structure, somewhat the worse for age and wear, is still in fair state of preservation. It is now occupied as a place of residence by a number of negro families. The old office in which McDowell is said to have performed the first ovariectomy on Mrs. Crawford, is now used by some negroes, it said, as a clandestine liquor shop. For some unknown reason the writer was not permitted to enter this office. Perhaps his mission was misunderstood.

The McDowell monument, erected by the profession of Kentucky, to the memory of the distinguished ovariectomist, is an imposing shaft and for many years will commemorate the deeds of woman's great benefactor. It will crumble into decay long before the name of McDowell disappears from the pages of history. Perhaps of all the great names in American history, McDowell's will be the longest preserved in the annals of time. His will rank with Hippocrates, Aristotle, Galen, Hunter, Harvey and Jenner.



Selected Articles.

REMARKS ON EPILEPSY.\*

BY E. D. FISHER, M.D., NEW YORK,

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It is with considerable hesitancy that I approach this subject, fully comprehending its difficulties and my inability to adequately handle it.

The character of the times seems to render it almost impossible, in the great number of conflicting duties and occupations of the hour, for one to concentrate his time and mind on any one subject.

In the department of diseases of the nervous system, one at present finds it necessary to know more of general medicine outside of any special knowledge of this department itself than what a few years ago would have constituted a liberal education in medicine.

The object of my paper will be emphasize the idea of the cerebral character of epilepsy, and to place it in the class of organic diseases, rather than its generally accepted classification as a functional disorder.

As Gowers, in "Diseases of the Spinal Cord," well says: "Strictly speaking, a functional disease is one which consists in a disorder of function without any preceding alteration of nutrition," and affections of the nervous system which can be included under this head are very few.

In most cases of so-called functional disease we must assume changes in nutrition.

Ross, in the last edition of his work on nervous diseases, defines epilepsy as a chronic functional disease of the nervous system, characterised by loss of consciousness, and convulsions.

Krafft-Ebing in his "Lehrbuch für Psychiatrie," describes it as a disease marked by repeated attacks of complete or incomplete loss of consciousness, or even slight dullness of intellect, accompanied by partial or general convulsions

dependent on spasm of the cerebral arteries.

Brown-Séquard has, perhaps, given us the most satisfactory definition. He says: "Epilepsy seems to consist in an increased reflex excitability of certain parts of the cerebro-spinal axis, and in the loss of control that in the normal condition the will possesses over the reflex faculty."

He places its cause as in the medulla.

The disturbance of the functions of the cerebral lobes during and immediately after a fit, and in the interparoxysmal period, he ascribes as due to alteration in the cerebral substances taking place during the seizure.

The hitherto mysterious coincidence of loss of consciousness, or, in other words, loss of function of the cerebral lobes, with increased action of the medulla, in an epileptic attack, is thus easily explained.

In describing epilepsy, great stress is laid on the character of the seizure, the attending epileptic cry, the unilateral or bilateral form of the convulsion, and but little attention is paid to the previous mental state, or to the condition in the intervals between the attacks—that which is called by Nothnagel the epileptic condition.

I do not refer to the status epilepticus, that condition immediately following a paroxysm, in which the patient may be in a state of mania, or in which paroxysm may follow paroxysm for hours or days, but I mean the period intervening between the attacks, be it six days or as many years.

The question is, then, What produces this epileptic condition, and what the outbreak of the seizures?

It seems to me the confusing of these two has caused the confusion in our ideas of the nature and seat of the disease.

Unconsciousness and convulsions may be produced by various causes. We know excessive loss of blood, ligation of the carotids, local or general cerebral anæmia, may account for them.

Bernard, on cutting the sympathetic in the neck and extirpating the superior cervical ganglion, caused an increase of

\*From the *Journal of Nervous and Mental Diseases* for August, 1886.

temperature on that side of the brain.

Nothnagel found that, after performing the above experiment, irritation of the crural nerve caused contraction of the vessels of the pia mater, and while cutting of the sympathetic caused the dilatation of the vessels, faradization of the cut extremity caused narrowing. Van der Beke and Callenfels obtained similar results. The author then states:—these experiments prove three things: first, that the vasomotor nerves for the vessels of the pia course in part through the fibres of the sympathetic in the neck; and, second, that perhaps another set, more important, pass through the superior cervical ganglion; and, lastly, that above the ganglion are fibres probably accompanying the cranial nerves.

This would explain, in the reflex epilepsy following teething, intestinal irritation, and injuries, the contraction of the vessels of the brain which follows.

There may be other causes, however, for convulsions besides cerebral anæmia. The cerebrum can be removed, and yet convulsions follow. Marshall Hall long ago stated that anæmia of the medulla oblongata was the cause of convulsions. There is no doubt that irritation of the medulla can cause them, and were this all of epilepsy, we might well rest our case with this part of the nervous system as the seat of the disease. Nothnagel has proven the existence of the convulsive centre in the medulla, and the presence also of the vasomotor centre explains, by its producing cerebral anæmia, the accompanying unconsciousness, but this does not explain the intellectual deterioration present, the epileptic condition to which I have already referred, and which I regard as the most essential feature of the disease.

Cerebral congestion was for a long time held as the cause of epilepsy, but Brown-Séquard, Bernard, Schiff, and others have proved that this is secondary to the convulsion.

Trousseau says of this:—there are therefore two very distinct conditions in an attack of eclampsia or epilepsy whether idiopathic or symptomatic: first, a cerebo-spinal modification unknown in its nature, which in a second abolishes

all the manifestations of animal life, and second, a secondary cerebral congestion, which, although less important, may in some extremely rare cases be carried so far as to produce subcutaneous ecchymoses, cerebral capillary hemorrhage and even meningeal hemorrhage. In the interval between the seizures there is a change in the individual. We may have mania or delirium continuing for weeks; there is a marked loss of intellectual power, and of memory, an indefiniteness of ideas, an irritability of temper, or, as Esquirol puts it, if not insane, the character is peculiar, irritable, capricious, paradoxical, the features become coarse, a precocious senility sets in.

Who has not observed the obstinacy of the epileptic, the look of vacancy or fatuity, the mental weakness?

In the cases that have come under my observation in the last five years, few if any have preserved their full intellectual power. This would speak against the theory of regarding the seat of the disease as in the medulla.

Extensive implication of the medulla, as in primary and secondary bulbar paralysis, does not involve the intelligence. I have two cases of that nature at present under observation, where the intelligence is absolutely intact.

I also protest against calling a single convulsive seizure caused by teething or indigestion, as epileptic.

Should these attacks continue, then, as a result of repeated sensory irritation conveyed to the brain, the cerebral cortex may become involved. Chronicity must be present in this disease as a factor.

The cortex is the location of all psychical processes which are present to our consciousness; it is the seat of memory and all acts of the will (Edinger).

In general paralysis Tuczeck shows the first layer of the cortex is first involved, and so in order to the fourth. Not until the first month of life, however, do the cerebral fibres assume a sheath, and until then the child's acts are all reflex.

The fibræ propriæ or association fibres are the first to assume this sheath, and these fibres play an important part in



the extension of an epileptic seizure.

When we have simply loss of certain mental functions, as paroxysmal attacks of loss of words, or loss of the power of reading, which may precede the seizure or be present without the latter, we may well conceive that certain convolutions containing the centres of these attributes are affected.

Should this extend its irritative action, the surrounding centres controlling motor or sensor functions might be involved, and thus lead to a more extended class of symptoms.

Epilepsy *per se* is a chronic condition or disease of the cerebral cortex, manifesting itself by periodical attacks of convulsions, etc., with a progressive intellectual decline and tendency towards insanity, and belongs to the class of cases coming under the head of general paresis.

Simple convulsions are distinguished by their constant relation to some known cause, and by their yielding to treatment directed against it. Hitzig speaks of the continuance of the epilepsy after the removal of the irritation. I think this sustains the idea of a morbid process having been established. The cause may have been removed; the condition however, has been induced, and now we find the permanent symptoms of the disease present.

The tendency at present is to regard the loss of consciousness, be it slight or great, with or without spasm, even dizziness,—in fact, any alteration of mental activity occurring paroxysmally, as epilepsy. I certainly hold with this view. I would look upon the epileptic seizures as simply expressions of the disease as existing in the degeneration of the gray matter of the cortex. It may involve any part, as the centre of speech or a motor centre, causing loss of control over the lower centres in the medulla, and thus lead to convulsions. Just as Bright's disease is accompanied by uræmic convulsions, the latter not being the disease but simply an expression of the diseased condition of the kidney, which may produce a large number of other changes in the system, so in epilepsy, we have various consequences of

the morbid state express themselves in convulsions, mental weakness, or even insanity. In the one we have arrived at a definite knowledge of the pathological changes, in the latter we have not as yet, but should look for them in the cortex. If in the frog, after removal of the cerebrum, the reflex acts are increased, it is fair to presume that in epilepsy, the cerebral centres being for the time in abeyance, the lower spinal and medulla centres, being no longer inhibited, are subject to increased reflex action on the slightest external irritation. Let the cerebral loss of function be produced by anæmia, or otherwise, does not affect the principle. If we consider that cerebral irritation is capable, independent of lesion of the medulla, of producing convulsions and loss of consciousness, it seems more probable, in consideration of the many mental symptoms present in epilepsy, and which can only have their origin in the cortex, that the cerebrum is also the original seat of the convulsions.

Hysterical attacks, although as violent as epileptic convulsions, do not lead to any condition similar to that of epilepsy.

Who has not observed the tonic and clonic contractions in hysteria, involving the face, extremities, and trunk, and even partial loss of consciousness? and yet, although this may be often repeated the after-effects never resemble those seen in epilepsy. The definition of the disease as given in the earlier part of this paper, in which it was described as a sudden but temporary loss of function of any or all the cerebral centres, is hardly correct, as implying that between these attacks a condition of restoration of cerebral function exists. As Krafft-Ebing has well put it, the epileptic shows a psychological degeneration, a loss of intellectual power up to complete imbecility, showing itself by forgetfulness and slowness of judgment and perception. I would therefore, define epilepsy as a disease of the cerebral cortex, attended by a progressive decline of the intellectual powers and by paroxysmal attacks of partial or complete loss of consciousness, accompanied by convul-

sions involving a part or the whole of the body.

In reference to the treatment of epilepsy I depend on the bromides exclusively, usually commencing with thirty grain doses three times a day.

I prefer, as a rule, the mixed bromides, in the proportion of four parts of the potassium bromide to two parts each of the sodium and ammonium bromide; when cardiac weakness is present, employing digitalis or aromatic spirits of ammonia.

I have not found, as some affirm, that iron acts deleteriously—that is when anæmia is present. Nor does the continued use of the bromides for years even, in my experience, lead to any mental disturbance; in fact, I find a gradual improvement in this respect whenever I succeed in controlling the disease.

In regard to cure of the disease, in my opinion that is less often accomplished than amelioration of the condition.

## EXPLORATION OF THE BLADDER BY SECTION THROUGH THE PERINEUM.\*

BY HENRY SMITH, F.R.C.S.,

Professor of Surgery in King's College, Surgeon to King's College Hospital.

On recently making an examination of a man who had undergone this operation in the hospital, I drew the attention of my class to this particular case, and made some remarks on the proceeding generally as a remedy for those distressing cases of bladder affection which are chiefly marked by excessive irritability of the organ—a condition which, dependent as it is upon various causes, has hitherto been deemed, if not incurable, at least extremely difficult to relieve with effect. Lately, however, this operation of cystotomy, so-called—which is a bad term, as the bladder itself is not cut into,—has been prominently brought forward by Sir Henry Thompson, and has been attended with

the best results. I have had several opportunities of putting it in force, the patient alluded to being the last of three who had been in the ward at the same time, and each being entirely relieved of their severe troubles. The principle of the operation consists in searching the bladder by means of an incision carried through the perineum into the membranous portion of the urethra by the middle line, removing any cause of irritation which might be found, such as morbid growth or undetected stone, and then thoroughly draining the bladder by means of a tube fixed in the opening thus made, and thus giving the organ complete rest. It is somewhat curious that the proceeding in question had not been established long since, as in my own knowledge Sir William Fergusson, upwards of thirty years since, had performed a somewhat similar operation for relief of an extreme case of irritable bladder in an old man, with excellent results. I recollect well Sir William discussing the matter with me before the operation. Like other good things, however, it was laid on one side for a time, but it now bids fair to become a thoroughly established proceeding and to be eminently useful and a credit to surgery.

I wish to say a few words about each of the three cases which have been recently under my care, more especially as, though the operation in each was the same, and performed with the same object, the cases differed somewhat materially.

The man whom I have referred to is between fifty and sixty. He had suffered upwards of six years from extreme irritability of the bladder, for which he underwent various forms of treatment in hospital and elsewhere, without relief. On admission the man was pallid and worn, and presented in a marked degree most of the signs of stone in the bladder, the chief feature, however, being the excessive irritability of the bladder. There was also some induration of the right testis. There was not any stricture, and careful and repeated use of the sound failed to detect any stone. Various means of relieving the intense

\*From the *London Lancet*, August 28th, 1886.



irritability were used without effect, and it was then determined to explore the bladder. On performing the operation I was enabled to feel the interior of the organ, which was found to be thickened and contracted, but there was not any foreign body. The relief, as in other cases, was marvellous, the patient, for the first time for years, having passed a tranquil night, and he soon became free from all his sufferings. The tube was retained for several weeks, and was then removed. Some, however, of his symptoms returned, and it was thought advisable to reintroduce and retain it for a few weeks longer, when, the man's health being completely re-established, the tube was removed, with the happiest result. A full-sized catheter was passed three times daily, the actual cautery, by means of a hot wire, was passed into the track of the wound until it was completely healed, and the patient is about to leave the hospital, he having gained considerably in weight. This case, although not so successful in one sense as the other two, inasmuch as it was necessary to retain the tube so long, was in other respects more so, as the poor fellow's sufferings were not only much more intense, but they had existed for a very long period of time, and thus the relief was all the more striking.

The patient in the next case, who has only recently left the hospital, was a man aged thirty-eight, who had suffered much the same as the last patient, but not longer than two years. Many of the symptoms of stone were present, but on sounding him a foreign body could not be detected, and there was not any stricture. Treatment of all kinds had been adopted in a London hospital and elsewhere without relief. The operation was performed in King's College Hospital, with the result of giving immediate relief. The tube was retained only for ten days, the bladder was washed out daily with hot water, a catheter was passed through the urethra three times daily, the application of the hot wire through the perineum closed the wound, and he was discharged well, having been taught to pass an elastic catheter for

himself. In this case the result was very satisfactory also, as it was not needful to allow the tube to remain in the wound for a longer period than ten days. This was due to the fact of the symptoms not having lasted anything like so long as in the case previously detailed.

In the third case the operation was performed in a similar manner, but not for the same condition of things as obtained in the other men. The patient, who was a dissipated costermonger, aged fifty-five, well known at the hospital both from his distorted visage and frequent attendance, had suffered from severe stricture for years, and had been under treatment at various times, with the result of producing great relief; but he neglected himself, and retention, atony of bladder, turbid urine, and re-contraction of the urethra supervened. This condition occurred in the last autumn, and he was admitted into the hospital. After some weeks he was dismissed, with his urethra well dilated. He, however, again neglected himself during the severe winter, and was readmitted in February, when it was found that, although a good-sized catheter could be passed, the man could only expel a very small quantity of turbid urine at a time, and, moreover, he could not pass any except in the sitting posture. The treatment consisted in emptying the bladder thoroughly every few hours with the catheter, but the only benefit resulting was an improvement in the condition of the urine. The operation was therefore determined upon with the view of exploring the bladder and thoroughly draining it, for it was surmised that something would be discovered which acted as an impediment to the passage of urine except in the sitting posture. On performing the operation and introducing the finger into the bladder, it came into contact with what appeared to be a prominent fold of hypertrophied mucous membrane on the left side, but not distinctly circumscribed or pendulous. A tube was introduced and fixed, and thus the bladder was kept thoroughly empty. Some serious bleeding occurred a few hours afterwards,

and it was thought advisable to introduce a tampon, which was retained for two days. The original tube was re-introduced, and taken out at the end of two weeks. A catheter was passed by the urethra twice a day, and the bladder was washed out daily with hot water. Six weeks after the operation urine ceased to come by the wound. In another ten days the patient was able to pass his urine freely whilst in the erect posture, and shortly afterwards was discharged well.

The cases referred to, with others which have undergone this operation, show what a valuable resource the surgeon has in the treatment of these severe affections of the bladder, and it may be resorted to as a means merely of giving relief in those instances where very severe suffering is produced by malignant disease of the bladder, and where nothing in the way of ordinary treatment is of any service. The operation itself, if cautiously and deliberately executed, as all procedures in connection with these parts should be, is neither difficult nor dangerous. The membranous portion of the urethra should be struck and freely opened so as to admit the point of the left forefinger, which is slowly and without force insinuated through the wound into the bladder, when, with care, the whole of the interior of the organ can be examined, and for the avoidance of bleeding as large a tube as possible should be introduced and fixed. Of course, if any foreign body, such as a stone or morbid growth, be detected, it is to be removed by avulsion or extraction.

### THE TREATMENT OF SYPHILIS BY SUBCUTANEOUS INJECTIONS OF MERCURY.\*

BY J. ASTLEY BLOXAM, F.R.C.S., ENG.

Surgeon and Lecturer on Operative Surgery, Charing-Cross Hospital.

The lecturer mentioned the excellent results which he had obtained at the Lock Hospital and elsewhere in the

treatment of syphilis by intra-muscular injections of a solution of the perchloride of mercury. The solution for injection contains six grains of the perchloride to the ounce of distilled water, and should be made fresh for each *séance*. Since he adopted this method, now a period of some eighteen months, upwards of 1500 cases had been treated with the best results. The sore generally begins to heal very promptly after one or two injections, the secondary symptoms are markedly modified, and after a course of treatment extending over a year, more or less, the patient is enabled to discontinue his attendance. Towards the latter end of the course of treatment the injections may be given less frequently, and as a rule not more than from eight to twelve grains of the perchloride are injected in all. It is undesirable to repeat the injections oftener than once a week, as otherwise salivation might be induced, and the quantity injected each time (one-third of a grain) is found quite sufficient until the next time. There are several advantages attending this method of exhibiting mercury. In the first instance it is only necessary to see the patient once a week when sufficient mercury is injected to last until the following week; secondly, salivation is not produced, as when the patient continued to take mercury for a whole week away from the supervision of his medical attendant; thirdly, the gastric derangements which are so apt to follow the administration of mercury by the mouth are by this means avoided; lastly, the ease and certainty of the administration, which enable the surgeon to do his own dispensing with a minimum of trouble. A little quinine is generally given during the course as a tonic, but no other form of mercury administered.

The injection itself is a very simple operation, but certain rules have nevertheless to be observed in order to obviate any inconveniences which might otherwise result. An ordinary glass hypodermic syringe is used with a fine needle (the needle is apt to become very brittle from the action of the mercury on the steel and requires to be replaced from

\*From *London Lancet*, August 21, 1886.



time to time), containing twenty drops of the solution, equivalent to one-third of a grain of the perchloride. After filling the syringe the needle is freed from adhering solutions by washing in order to avoid irritation in its track, and is then plunged deliberately into the muscular tissue of the buttock, selecting for this purpose the spot corresponding to the muscular mass of the glutei into the substance of which the injection is made. If this precaution be observed no discomfort or abscess formation follows, the only solitary case in which this has occurred being attributable to the injection having been made into the areolar tissue over the trochanter. The pain of the injection is but slight and soon passes off. It is desirable that the patient should not take active exercise immediately after the injection, as it has been noticed that blood may be effused at the point of injection, giving rise to sensation of a severe bruise of the part, which lasts for several days. The same effect has followed the puncture of a large vessel, but in any case the result is only transient and disappears after the lapse of a few days. If for any reason the buttock be objected to as the site of the operation, the injection may be made into the trapezius muscle at a point two inches above the superior angle of the scapula, but the injection into the buttock is attended with less inconvenience.

Mr. Bloxam mentioned that his own opinions were strongly in favor of syphilis being bacillar in origin, thus accounting for the specific action of mercury in the treatment of the disease. In support of this view he alluded to the remarkable reseaches of Messrs. Eve and Lingard, whom he had furnished with blood and chancrous tissue from patients at the Lock Hospital, the subjects of syphilis. They have succeeded in detecting and cultivating a bacillus which could generally be found in the blood and tissues of syphilitic patients who had not been subjected to the influence of mercury, or who at any rate had not taken it long. In a contribution to *The Lancet* of April 10th, 1886.

they say: "In none of the cases from which cultivations were obtained had mercury been administered for any length of time, and a long series of failures have led us to reject entirely cases which have been long under mercurial treatment." With this fact in view, the importance of obtaining a thorough and certain permeation of mercury in the system is apparent, and without claiming any originality in this method of treatment, the lecturer wished to bring before them the extremely favorable results he had obtained from it.

### Clinical Notes.

A FORMULA FOR HYSTERO-MANIA.—  
Dr. A. L. Hodgdon, of Farmwell, Va., writes:

The following formula I have found useful as a calmative in hystero-mania (hysterical insanity).

R.

Extr. Cimicifig. fluid . . . .	℥jss.
Extr. Vibur Prunifol. fluid . .	℥j.
Extr. Conii fluid . . . . .	3j.
*Tincture Cannab. Indic. . .	℥iss.
Syrup . . . . .	3x.

M. Et. Sig.—Two teaspoonfuls three times a day, and see that its components are thoroughly mixed before exhibiting. Two of the ingredients of the formula before mentioned—the hemp and the hemlock—are of notoriously uncertain strength. Hence the proportion of each of these drugs to the rest of the prescription must always be governed by their respective strengths, and the mixture should never be administered excepting with extreme caution, carefully watching its effects.

\*The tincture of hemp used in the formula was made from the English extract and alcohol, in proportion of 3i of the extract to 3ii of alcohol.

### Abstracts and Extracts.

#### ETIOLOGY OF GONORRHOEAL ARTHRITIS.

—Dr. Smirnoff, writing in the *Vrach* on the etiology of gonorrhœal arthritis, remarks that inflammation of the joints occurring after an attack of gonorrhœa has for a long time been looked upon as an outcome of some sort from the urethral disease, but although the genetic relation of the latter to the joint disease was generally allowed, the mode in which the metastasis takes place still remained in obscurity. It was said that the poison, which was probably of a chemical nature, found its way into the blood, and was thus distributed through the body, and so set up the joint inflammation. Since Neisser succeeded in finding gonorrhœal micro-organisms the cause of the arthritis ought to be more satisfactorily ascertained. Indeed, Petrone, Kemmerer and Prof. Afanasieff have actually demonstrated the presence of gonococci in the exudation, of the joints in gonorrhœal arthritis. Taking into consideration, however, the fact that the significance of Neisser's gonococci in the etiology of gonorrhœa is not universally accepted, it cannot be considered that the arthritic inflammation is satisfactorily accounted for. An observation made by the author for the better elucidation of this matter in the Kazan Pathological Institute on the contents of a knee-joint affected with gonorrhœal arthritis is therefore of considerable interest. The case was that of a man of twenty-eight, in whom gonorrhœa showed itself on Jan. 1st, 1886. On the 5th orchitis supervened in consequence of too active exercise and on Feb. 1st the right knee became inflamed. After about a fortnight Professor Studenski drew off fluid and washed out the joint. The quantity was about three ounces, and it was of a sero-purulent character. Thin films of it were placed on cover glasses, dried and stained with methylene blue (1 part to 33 of alcohol and 66 of water), remaining in the solution about a minute, and subsequently washed with water and re-dried. The examination was conducted by means of a Zeiss's oil immersion  $\frac{1}{2}$  objective. Quantities of gonococci were seen in

the preparations mingled with pus-corpuscles. Dr. Smirnoff is therefore able to confirm the previous observation of Petrone, Kemmerer, and Afanasieff as to the mibrobic origin of gonorrhœal arthritis.—*Lancet*, Aug. 28.

THE MICROBE OF SYPHILIS.—The following account of some of the most recent investigations in this subject is abstracted from the *Wiener Medicinische Wochenschrift*, No. 14, 1886. At a recent meeting of the Berlin Society for International Medicine, Klemperer reported that he had treated preputial smegma, taken from nine healthy individuals, according to Lustgarten's method. He found in every specimen the smegma-bacilli described by Alvarez and Favel. These, like the syphilis bacilli, differ so greatly in length, thickness, and form that there is some doubt whether they belong to the same species. They resembled the syphilitic bacilli in appearance and in reactions, but were more readily decolorized by acids and alcohol than were the latter. The speaker had found Lustgarten's bacilli in the secretion of broad condylomata, but had never found them in sections of condylomata, indurated patches, or gummy tumors. Köbner said he had found the presence of the bacilli in the secretions, and especially in sections, of syphilitic lesions to be very instant. He doubted the identity of Lustgarten's bacilli with the syphilitic virus. Finger had shown that the micro-organisms were present in the secretions in all three stages of syphilis. Were, then, these bacilli the bearer of the specific virus, he did not understand why the disease could be transmitted by the secretion in the first and second stage, but never by those of the third.

In an article on the "Contagium of Syphilis," in the *Deutsche Medicinische Wochenschrift*, Disse and Faguchi state that have they found spores in the blood and short bacilli in the indurated patches and papules of syphilitic patients. They also obtained from the blood of syphilitics pure cultures in gelatin and meat broth of a bacillus, which caused syphilis in dogs, sheep, rabbits, and white mice when inoculated. An induration



occurred at the point of inoculation and was followed some months later by gummy tumors in the internal organs. From the blood of these animals could be cultivated the same bacillus as from the blood of syphilitics.

Matterstock has recounted in a pamphlet the results of his studies in the clinic of the University of Würzburg. He found the bacilli corresponding to Lustgarten's description, in sections made from sclerosed patches, papules, broad condylomata of the genitals and anus, and gummy tumors of the skin. These lay, from one to four together, in cells two or three times the size of white blood-corpuscles; and in rare instances a few solitary rods were found lying free between two cells. The bacilli were found in great numbers in the secretion of papules, which, from their protected situation, covered with long-standing secretion, and at a constant temperature, resembled miniature culture-ovens. Experiments upon the smegma-bacilli had led to the same results as those obtained by Alvarez and Fayel. He had found no reliable means of distinguishing between these and Lustgarten's bacilli by staining methods. His conclusions were that not only was the etiological significance of Lustgarten's bacilli not demonstrated, but even their diagnostic value was nil, since they could not be distinguished by their reaction to coloring agents from other bacilli.—*Journal of Cut. and Ven. Dis.*

POISONING BY ICE CREAM.—PROF. V. C. Vaughan, writes in *Science* as follows: "No chemist certainly would suppose that the same poison exists in all samples of ice cream which have produced untoward symptoms in man. Mineral poisons, copper, lead, arsenic, and mercury, have all been found in ice cream. In some instances these have been used with criminal intent. In other cases their presence has been accidental. Likewise, that vanilla is sometimes the bearer, at least, of the poison, is well known to all chemists. Dr. Bartley's idea that the poisonous properties of the cream which he examined were due to putrid gelatine is certainly a rational

theory. The poisonous principle might in this case arise from the decomposition of the gelatine; or with the gelatine there may be introduced into the milk a ferment, by the growth of which a poison is produced.

But in the cream which I examined, none of the above sources of the poisoning existed. There were no mineral poisons present. No gelatine of any kind had been used in making the cream. The vanilla used was shown to be not poisonous. This showing was made, not by a chemical analysis, which might not have been conclusive, but Dr. Novie and I drank of the vanilla extract which was used, and no ill results followed. Still, from this cream we isolated the same poison which I had before found in poisonous cheese (*Zeitschrift für physiologische chemie*, x, heft 2) and demonstrated its poisonous properties by experiments upon cats. Moreover, by adding a piece of the solid portion of the poisonous cream, about the size of a filbert, to some normal milk, and making cream with this milk, following the details of the maker of the Lawton cream, omitting, however, all flavoring, I obtained a highly poisonous cream. Does this not prove that the poison may be produced by fermentation in good milk? A detailed account of my experiments may be found in my report to the Michigan State Board of Health."—*Boston Med. and Surg. Jour.*

AN AMICABLE DISCUSSION OF HOMŒOPATHY.—We have already alluded to the polite controversy which has been taking place in Boston between regular physicians and the homœopaths of the University Schools of Medicine. Dr. Conrad Wesselhoeft having last year delivered a lecture on homœopathy before Boylston Medical Society, Dr. V. Y. Bowditch this year delivered an address on homœopathy before the Hahnemann Society. Dr. Bowditch's address was directed to the answering of a number of set questions propounded by the homœopaths. In answering these questions the lecturer presents the position of rational medicine toward dogmatic medicine in a courteous, yet logical, and

forcible, manner. We cannot but believe that such efforts as those of Dr. Bowditch will help to infuse into the profession a more fraternal feeling. The splitting of the profession into "schools" lowers us continually in the eyes of the public. Dr. Bowditch reminds us that while individuals disagree, there is a common bond of unity which cannot be ignored by honest men. "We are *all*," he says, "members of a profession which, when regarded in its true light, above the plane of party strife and mere selfish gain, I regard as the finest and noblest of all, and the feeling grows stronger within me with each year of practice. There is that in it far above the mere desire and ability to cure disease—that which can smoothe all regrets for possible failure and disappointment in our daily work—I mean the power of human sympathy; the power which bids the young mother silently and gratefully press the hand that helped her in her hours of trial; the power that impels the dying man, at the very last to turn to him who, though powerless to save, yet, by a word, a look, a touch of the hand, gives strength and courage to one just passing to that 'undiscovered country from whose bourn no traveller returns.' In the midst of discord and disappointment let us keep this thought before us, gentlemen, and at the end perhaps we may be permitted to see our past life, as it were, stretched before us, and feel that we have done our small share toward making our chosen profession what it should be—a blessing to all mankind."

Such sentiments as these should ever be borne in mind by the physician. They will be a better help to a successful life than a whole bookful of worldly wise instructions as to how to dress up "the physician himself." — *Med. Record*, Sep. 4th, 1886.

**SUBLIMATE INJECTIONS IN GONORRHOEAL CYSTITIS.**—The history of an obstinate case of gleet and cystitis is given in *El Dictamen* by Senor Garcia Andradas, which after being treated successfully by means of injections of nitrate of silver, yielded very quickly to

injections of corrosive sublimate. The patient, who was a river fisherman, contracted gonorrhœa, which was treated for a month with balsams and astringent injections. The discharge then became serous, and exquisitely painful vesical tenesmus supervened, the calls to urinate being so frequent as to give the man no rest. An attempt to pass an instrument occasioned the greatest agony when it came in contact with the prostatic portion of the urethra. The diagnosis made was that of acute prostatitis consequent on gonorrhœa, and so the local application of a sublimate solution appeared to be the most rational treatment, as it had in the author's hands proved very beneficial in cases of sub-acute cystitis due to the same cause; but it was thought well to try first Guyon's treatment. With great difficulty, owing to the extreme sensitiveness of the urethra, an elastic catheter was passed to the prostatic portion, and ten grammes of a 1 per cent. solution of nitrate of silver injected. A few minutes afterwards urine was passed with great pain, so a warm bath and an opiate were ordered, which gave only temporary relief, the opium having to be repeated at night. The next day the patient's condition was the same as it had been before the injection. Three or four days afterwards a similar injection was given, with no better result. Four days later, as there was no improvement, the use of sublimate injections was commenced. The catheter was passed as far as the prostate, and forty-five grammes of a 2 per mille solution of sublimate in warm water were injected. This the patient was compelled to retain for three minutes; the subsequent micturition was very painful, but at night he was able to rest and retained his urine for three hours. The next day the urine was less turbid, and it was voided less frequently. His condition continued to improve for three days, when a second sublimate injection was given of double the quantity of solution. This occasioned some pain, but it quickly passed off and the patient was able to rest. In four day's time he requested to be discharged, as his urine was clear and he had no pain on micturi-



tion. Thus, the author remarks, two injections sufficed to cure completely an affection usually most obnoxious to treatment of an ordinary kind. The superiority of sublimate injections has shown itself in several cases of a somewhat analogous character in which he has employed it. These he proposes to publish and discuss on some future occasion.—*Lancet*, Aug. 21, 1886.

**TOPICAL APPLICATIONS IN DISEASES OF THE SKIN.**—An interesting paper with this title, by Dr. H. G. Brooke, appears in the *Medical Chronicle*. After pointing out that a local treatment of skin diseases is gaining ground, the author admits that patients are often prejudiced against it, but says this lack of confidence is largely due to the imperfect way in which the local applications are made by the patients themselves. They are usually provided with a box of ointment, and then left to their own resources, with frequently insufficient directions. But if the patients have to undertake dressings on a large scale, there is a great deal of trouble involved, and a serious loss of time to the doctor if he has to undertake the task himself; and any form of treatment which involves much trouble or expense to the patient is pretty sure to be imperfectly carried out or neglected, with discredit to the doctor and dissatisfaction to the patient; hence an easy, inexpensive, and at the same time effective mode of application is a desideratum. For this purpose he praises the salve muslins and gutta-percha plasters of Dr. Unna, but finds that they have one or two drawbacks, the chief one being expense. He therefore devised another method, by having medicaments made up with a very stiff basis of wax, cocoa-butter, and oil, and cast into the form of a stick of cosmetic. This, when rubbed on the skin, is sufficiently soft to leave a complete coating of salve, and sufficiently hard not to run. On the body of a piece of impermeable adhesive plaster may be placed over the annointed spots, the patch of plaster being sufficiently large to overlap the ointment by half an inch. Another basis which he found of great

use consists of a mixture of equal parts of almond-oil and thick gum-water. This makes a creamy emulsion, which, when well rubbed into the skin, soon dries and leaves an almost invisible coating. A fifteen to twenty per cent. solution of salicylic acid in this oil-gum is recommended in cases of chronic eczema and lupus, and a ten per cent. solution of pyrogallie acid proved very efficacious in psoriasis. No protective dressing is necessary. He then notices Pick's gelatin and glycerin base, as modified by Unna and Beiersdorf, the only drawback of which is its deficient adhesiveness. This he has endeavored to remedy by the addition of gum. Collodion, especially flexible collodion, is another useful base, as is also compound tincture of benzoin. This being thin and limpid, penetrates well and adheres firmly. Lastly he recommends that tar should be applied as an ethereal and alcoholic tincture; if this be painted on the skin it quickly dries, leaving only a brown stain with very slight odor. The tar tincture thus forms a smooth protective, and almost waterproof covering, which may also be made to serve as a vehicle for other drugs, as salicylic acid, zinc oxide, etc.—*Journal Cut. and Ven. Diseases*.

**PSOAS ABSCESS; WHEN AND HOW TO OPEN IT.**—At the recent meeting of the British Medical Association Mr. Edmund Owen read a paper on the above subject. Mr. Owen said there was no disease the treatment of which had derived a greater impetus from the introduction of antiseptics than psoas abscess. By antiseptics he did not mean the use of the spray. The spray was now cooling down in more senses than one, and the surgeon did not now have to look through a cloud of carbolic vapor at his patient. By the use of antiseptics he meant antiseptics as used by the great masters in surgery, whether by Tait, Gamgee, Savory, or Lister. Twenty years ago every surgeon preferred to leave a psoas abscess alone so long as it remained unopened. Stanley, writing forty years ago, said a psoas abscess might disappear. Could it? Mr. Owen said that

in an extensive out-patient experience, extending over years, he had only seen one case in which, after a fusiform tumor had been detected ascending along the iliac fossa, he had seen it disappear. Aspiration was useless, for it refilled. When evacuation of the abscess was performed, it should be done thoroughly, and no useless temporizing measures made use of. During delay the pus would be burrowing out for itself an extensive ramifying cavity. A free anterior and posterior opening should be made, and the wound thoroughly drained. The sac should be washed out with a warm antiseptic lotion, and a drainage-tube the size of a cedar-pencil passed through. The wound should be covered with sublimate gauze, then some oakum placed over it, and the dressings changed as seldom as possible. He had employed as the antiseptic lotion a warm solution of corrosive sublimate (1 in 1,000). He should, however, in future discard the use of the sublimate, as he had had a case which died in four hours with black urine, due, he believed, to the absorption of the sublimate. Mr. Owen, in concluding, summed up his conclusions as follows:

1. Spontaneous absorption of psoas abscess is impracticable. Sooner or later it must be evacuated, either by nature or art, and the advantage is on the side of art.

2. The sac should be opened both in front and at the back, and irrigated. For a small abscess a single opening, at the back might suffice.

3. Antiseptics should be employed.

4. The operator should bear in mind that pus might collect on the opposite side after evacuation of the abscess. If any rise of temperature take place, a second abscess should be suspected, and, if found, evacuated at once. Bilateral abscesses should be attacked simultaneously, as their cavities frequently communicate. In reply to a query from a member as to the source of his method, Mr. Owen replied that it was neither English, French, Scotch, nor Italian, but Welsh, thereby signifying that the idea was his own, and that he had not borrowed it from any one.—*Medical Record*.

DR. WENDELL HOLMES.—Dr. Holmes has unfortunately left us long before we have had such opportunities as we could have wished of expressing our welcome to him. At the last moment, as the guest of the Liverpool Philomathic Society, he spoke kindly words of affection and respect for "dear, dear England," which he felt and appreciated everywhere. But, though gone, he is still with us as one of our most "autocratic" companions, teaching us great broad lessons of sympathy with all that is human and divine. His medical distinction may be somewhat lost in his literary fame, but we claim him nevertheless, as one of the men whose vision has been refined and intensified by the study of medicine, and who could not have drawn some of his most effective pictures of character and experience without this study. Who but a medical man could have done justice to "the little gentleman" with his diminutive and deformed body and his disproportionate thoughts or who else could have vindicated the true gentleness and kindness that underlie the apparent sternness and want of feeling of the surgeon. We trust he has received a fresh stock of health, and that in the atmosphere and association of the old country, which he loves like a true American he has found a source of fresh inspiration, the expression of which will delight the "break-fast-table" for generations yet to come.—*Lancet*.

THE TREATMENT OF TYPHOID FEVER.—The hope of cutting short the usual course of the specific fevers still lingers in the mind of practical physicians, though it must be confessed that there does not appear to be much encouragement in store. M. Pecholier of Montpellier is of opinion that he has discovered the means of causing the premature termination of ordinary cases of typhoid fever. The agent is the familiar quinine, administered in daily doses of not less than one gramme, and this from the very first days of the illness. The drug may be aided by the employment of tepid baths if there be considerable fever, and by small doses of digitalis should the heart be specially disordered.—*Lancet*.



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Editorial.

THE PIGMENTATION OF THE TISSUES IN MALARIA.—Of the pathological changes that are observed as a result of prolonged malarial poisoning, probably none are more conspicuous than the discoloration arising from the deposit of pigment in the tissues.

As to the anatomical changes which occur in simple remittent fever, but little can be said, as it is but rarely that an opportunity presents to study these cases at autopsy, for it is the exception for them to prove fatal. When, however, death does ensue as a result of intercurrent disease it is sometimes impossible to determine to which affection the departures from the normal are due.

The results, however, of anatomical investigations in the severer forms of the fever, in which fatal terminations are not uncommon, are more satisfactory. In the pernicious form for example, we detect deviations and changes that may be considered characteristic.

One of the most common changes that is noticed by its conspicuousness is a dark brownish or black discoloration of the different organs. This alteration in color is the result of the deposit of a black pigment in the form of granules, masses and flakes in the capillaries of the viscus under examination. It is seen to be present as fine granules, flakes and masses which are sometimes free in the vessels, again they are encased in leucocytes, while here and there they may be detected embedded in large

masses of protoplasm that circulate with the blood through the vessels.

The changes that are pronounced as a result of the presence of these pigment granules, are most characteristic in the gray matter of the brain, the spinal cord, the cortical substance of the kidneys, the liver, spleen and lymph glands. When occurring in any quantity in the brain it gives rise to such an appearance, which when once seen, it is difficult to forget. This alteration is so graphically described by Dr. Meigs that we take the liberty of quoting his remarks upon the subject. He says: "I have never before seen a brain presenting such an appearance; it was leaden colored throughout, as long ago described by Morgagni, who is quoted at length by Frerichs. The hue of the gray matter was most singular. It looked as though it had been washed over with a not very weak solution of India ink. I examined my specimens with the microscope. In every one of these, all the capillaries were unusually distinct, and were crowded with black pigment in the form of granules lying in the calibre, or deposited, apparently, in the walls themselves. There existed, also, scattered through the cortical brain substance isolated grains of pigment, much too large to be embraced in a capillary tube. It was evident that the general dark color of the cerebral tissue and substance of the spinal cord was due to the aggregation of these minute grains and granules. Wherever the blood had gone it had taken the pigment, filling the capillaries and lodged it in the tissues. To the naked eye, and more particularly to the eye aided by a pocket lense, the fine vessels of the white medullary matter were everywhere visible, resembling, as Dr. Bright aptly remarks, 'the appearance produced by scraping the nap of fine cloth on a sheet of white paper.'"

The term "bronzed liver" employed by Dr. Thos. Stewardson, in his paper on "Bilious Fever," expresses most accurately the gross appearance of this viscus. The liver is enlarged, of a dark bronze color and on section, gives somewhat of a metallic lustre by reflected light. By the aid of the microscope its

capillaries are seen to be filled with this dark coloring matter. In some places it is observed as free granules, while again it appears as masses in the blood. White blood cells are seen whose protoplasm may be almost completely studded with these flakes and granules. Large masses of non-nucleated protoplasm filled with this pigment may here and there be detected in the capillaries.

The enlarged and congested spleen likewise contains them in a considerable amount. In fact, it may be briefly stated, that whereas the gross changes are greatest in the organs enumerated, yet wherever there is a capillary, search will reveal the presence of a greater or less amount of pigment.

The origin of this pigment in chronic malaria has been a topic for discussion for some time and while many hypotheses, and apparently well grounded ones, have been advanced, still, we have as yet not arrived at a positive and generally accepted solution of the problem.

The spleen has long been held to be the point of origin of this coloring matter, and it has been thought that it was distributed thence after the manner of emboli.

There seems also to be some evidence to prove that the liver is not without a share in its production; while other observers hold that it is found in the blood current independently of these viscera, and hold as evidence, that the large masses found in the vessels of the brain exclude the possibility of their having passed through the capillary systems of the liver and lungs.

In whatever locality, however, this pigment matter is produced it is highly probable that it is the result of disintegration of the red blood corpuscles.

Heschl believes that as the hæmatin is retained in the corpuscles by virtue of the presence of a certain amount of albumen and sodium chloride in the plasma, so changes in the plasma which alter the normal proportion of these constituents are the cause of the escape of the hæmatin which is then converted into this pigment. These changes in the plasma he considers a result of the introduction into the system of the malarial poison.

The greater collection of the pigment matter in the capillaries of the brain, the cord, the spleen, the liver and the kidneys, leads him to suppose that the toxic action of malarial infection has the seat of its greatest violence in these organs, and that the larger amount of pigment herein found is due to the disintegration of the red blood corpuscles and the liberation of their hæmatin while in these viscera.

In this way may we account for the hydræmic condition of these patients. For in order for the production of such an amount of pigment, there must be a corresponding destruction of many red cells, thus the vessels are deprived of their proper nutriment, and as a result we have an exudation of the watery elements of the blood through the poorly nourished vessel walls into the surrounding cellular tissue, giving rise to the œdema so common in this affection.

This diminution of red corpuscles not only accounts for the œdema, but explains the heart palpitations, the dyspnoea and the readiness with which these patients become fatigued upon slight exertion. As a result of the lessened tone of the vessel walls we not uncommonly see epistaxis, ecchymoses and hemorrhages of a more or less severe character.

LAPAROTOMY IN EUROPE.—Under the above title Dr. P. F. Mundé, of New York, contributes to the *American Journal of Obstetrics* (September, 1886) a very interesting description of a visit to Europe, during the present summer, and a full account of his observations upon Laparotomy as he saw it performed by the leading surgeons of Europe. Dr. Mundé visited nearly all of the leading operators in abdominal surgery on the Continent, and in Great Britain. He describes the methods employed by each operator, and has presented an *ensemble* of practical suggestions which renders his article an exceedingly useful compilation of facts bearing upon abdominal surgery.

The paper is illustrated with reports of cases selected from the records of the different operators. Dr. Mundé witnessed twenty-five abdominal sections per-



formed by fifteen of the first laparotomists of Europe.

We shall not attempt to give a review of Dr. Mundé's paper. We commend the article in its entirety to those who are interested in this branch of surgery. Dr. Mundé finds himself unable to reply satisfactorily to the query why European operators in abdominal surgery excel us on this side of Atlantic. The main reasons which are assigned for this difference in results are these: "1st. Because in Europe laparotomies are more concentrated, fewer operators perform proportionately more operations, and therefore each operator acquires a greater dexterity and a more varied experience in handling difficult cases, that is, greater confidence."

This greater concentration of cases, Dr. Mundé, thinks gives the operator a larger variety for selection, and obviates the tendency to operate whenever there is a fair prospect of success. An operator with few opportunities will, he thinks, be likely to take more chances than who one is overburdened with material. "2d. The majority of European laparotomists, chiefly those who are clinical professors, have at their disposal operating rooms, clinics, and wards fitted up with every facility and with every modern contrivance for guarding against infection, and are assisted by a staff of trained aids, whom long experience renders familiar with every detail of the operation and after treatment."

The foregoing explanations given by Dr. Mundé are satisfactory in the main, but do not wholly account for the many failures on this side of the Atlantic. We have surgeons in this country of equal surgical dexterity to many of the most skilled European operators, and in other fields of surgical work our results compare favorably with theirs. It seems, however, that abdominal surgery in this country has been more generally practiced by surgeons who have entered upon this field with comparatively little training in the field of general surgery. In Europe this is less the case than in America. Abdominal surgery across the Atlantic is regarded more as a dis-

tinued branch of surgery, than as a special department of gynecology or obstetrics, and in consequence of this understanding of its requirements it has fallen into the hands of men who devote their time to abdominal surgery as distinguished from pelvic surgery. Undoubtedly a special training is demanded of one who wishes to achieve marked success in the field of abdominal surgery, for it is quite evident that more is required of the surgeon than a mere knowledge of the use of antiseptics, a special hospital, and a corps of trained assistant. Nor is it simply surgical dexterity which is to conquer the field of abdominal section. A study of the methods of the most successful European surgeons at once reveals the fact that they possess a comprehensive knowledge of surgery in all of its details, and they owe their results to a combination of favorable conditions which are the outcome of a larger skill and knowledge of the science and art of surgery in general. A study of the methods practiced by the leading abdominal surgeons of Europe also discloses the fact that no two operate under precisely the same rules. Whilst one class practices antisepticism in all of its details, another class repudiates the use of antiseptic agents, and employs simple cleanliness. Both get equally good results. The length of the abdominal incision does not appear to have any decided influence on the result.

The influence of climate and the constitutions of different races *pro or con*, Dr. Mundé thinks, must still remain undecided. As to the superior robustness of European over American women Dr. Mundé does not believe that such is the fact, unless we except the German peasantry, whose work in the fields gives them powers of endurance not possessed by the majority of our house bred women.

Dr. Mundé is very hopeful when he arrives at the conclusion that by a careful study and imitation of, and perchance eventually an improvement on the methods of the most successful foreign operators we may equal or excel them in course of time,

### Miscellany.

**PLUGGING THE TRACHEA IN LESIONS OF THE PNEUMOGASTRIC.**—In an article in the *Nordiskt Mediciniskt Archiv*, Dr. Jens Schou of Copenhagen discusses at some length the treatment of traumatic lesions of the pneumogastric nerve by means of permanently plugging or tamponing the trachea. Dr. Schou gives a succinct description of the doctrine propounded by Traube, that the pulmonary affection caused by section of the pneumogastric nerve is a pneumonia by aspiration—a theory which has lately been supported by other observers, more especially Gärtner. It appears that with animals the unilateral section of the pneumogastric or of the recurrent nerve is generally harmless; but in the human subject it causes pneumonia by aspiration. The reason seems to be that in animals the sections are effected without complications, whilst in men they are as a rule the result of some serious operation capable alone of causing a state of collapse from which pneumonia by aspiration might result. Here, one of the vocal cords is paralysed, which serves to increase the effect of the lesion. The treatment indicated is, then, permanent tamponing of the trachea till the end of collapse, by which time the healthy cord will be accustomed to replace the diseased one. Below's method—namely, tamponing above the canula—is recommended, an india-rubber ball above. Dr. Schou, however, prefers to introduce a tampon of some antiseptic material such as iodoform gauze. A tampon of this kind is easily applied by means of a cannula open above. If it be necessary to cut the pneumogastric or recurrent nerve, tracheotomy and tamponing should be immediately resorted to, in order to prevent the development of pneumonia by aspiration. Should some time have elapsed before pneumonia by aspiration fully developed has been discovered, it is still necessary as quickly as possible to do the tamponing in hopes of arresting the progress, for in these cases the nerve may be paralysed for some time.—*Lancet*, Aug 17.

**THE REMOVAL OF SUPERFLUOUS HAIRS BY ELECTROLYSIS.**—In this paper (*Birmingham Med. Review*) Mr. Gilbert Smith, after referring to the writings of Hardaway, White, and Piffard, proceeds to describe the apparatus needed, and the now well-known method of operating. Under a strong lens he finds it is not difficult to introduce the needle directly into the follicle, but this is not absolutely necessary, as the requisite destruction occurs if the instrument is in the immediate neighborhood. He recommends that not more than a dozen hairs should be removed at a sitting, owing to the papules and pustules which follow the operation, and says that minute scars are most apt to occur where it has been found necessary to introduce the needle into the same follicle a number of times, or where hairs situated close together are removed at one time; but even the most marked scars are scarcely noticeable after the first few weeks. He says that the operation is accompanied by pain which "is not unbearable," and that no return of hair has occurred in cases on which he has operated six months ago.—*Journal of Cut. and Ven. Dis.*

**EFFECT OF SUBCUTANEOUS FRACTURES ON BODY TEMPERATURE.**—E. Müller has recorded the rectal temperature in 36 cases of uncomplicated fractures, and found, in opposition to the observations of Maas, a rise in temperature in 35. The maximum was usually reached on the first or second evening, and was maintained for from one to thirteen days. Neither the age of the patient, the amount of extravasation, nor the extent of the fracture appeared to influence the extent of the rise in temperature. Müller has collected all the records of uncomplicated fracture (English, German, and American) at the time available to him, and finds that out of 359 cases, 308—85 per cent—passed through with marked rise of temperature.—*Centralblatt f. Chirurgie*, June 12, 1886.—*Medical News*, August 14, 1886.

**LIGATURE OF THE SUBCLAVIAN ARTERY.**—At the third meeting of the



Italian Surgical Society Dr. Lampiasi reported two cases in which he had successfully tied the subclavian artery, after failure of ligature of the axillary under the clavicle. In the discussion which followed a case was referred to in which, two years ago, Dr. Piccinini, at the Ospedale della Consolazione in Rome, tied the subclavian just outside the scaleni for wound in the highest part of the axillary artery. The result was satisfactory.—(*Gazzetta degli Ospitali*, August 4th.)—*Lancet*, Aug. 19th.

**BROMINE IN DIPHThERIA**—Senor Lovat A. Mulcahy, of Buenos Ayres, finds great advantage in cases of diphtheria in giving a solution of bromine. The bromine is simply dissolved in water in the proportion of 1 to 2500. A teaspoonful of this is given every ten minutes. He says that children will swallow it automatically even when asleep. For infants under three years of age the strength may be diminished to half that mentioned above. He cites several cases showing the successful results obtained by this method, but he points out the importance of the administration being continued for some days, and of the medicine being given exactly every ten minutes. As to local caustic applications, he considers that they serve no purpose whatever, but only irritate and distress the patient.—*Lancet*, Aug. 19.

**THE WEDDING TRIP.**—The French medical journals and some of the English have been lately calling attention to the evils of the wedding trip.

There are few physicians who will not recall many cases in which a girl, perfectly healthy till her marriage and a long wedding trip, is never healthy again. The number of women who date a life of chronic invalidism to a wedding trip is not small. So apparent have been these evils that it is reported a custom has arisen by which the demands of fashion for a wedding trip shall be complied with, and yet the newly married couple enjoy a period of repose, and quite all by themselves. The plan is to make ostensible arrangements for a

trip, and even drive to the station, but in reality turn back to a hotel or some intimate friend's in which all alone by themselves the newly married couple shall begin their life journey.

Marriage is one of the epochs of life. It is peculiarly related to the physical well-being of both parties and to the unborn. To the young wife, there has been long and exhausting excitement in arranging for the event. To this is added an entrance upon physical relations utterly new to her. Surely this is quite enough to bear in the retirement of a quite home, or away from inquiring acquaintances. Surely this is enough without the discomfort of railway travel, the exhaustion of hurrying from place to place, the excitement of new scenes and people, and the exposure to extremes of heat or cold, of storms, and all sorts of annoyances inseparable from long journeys.

We have often thought that physicians by giving a word of friendly advice to such of their patients as chanced to be about to enter upon a married life, might be the means of saving such persons from future misery. Family physicians are the ones to reach these cases. True, they would have to combat social customs, but after all we think that in the end they would win.—*The Amer. Lancet*.

**THE TREATMENT OF OTORRHOEA.**—Common as otorrhœa is very few physicians understand how to treat it intelligently and properly. The treatment is very simple and nothing is more satisfactory in its results. Supposing that the otorrhœa is uncomplicated with fungous granulations or polypi, the ear is first cleansed with a syringe and warm water. Then it is to be dried out thoroughly by twisting a soft rag and passing it down to the bottom of the meatus so that it will absorb all moisture from the ear.

Next sufficient boracic acid is put into the ear and worked down upon the drum so as to cover its surface. The powder should not be packed down upon the drum. It is allowed to remain there 24 hours, when the ear is again syringed, dried out, and the powder reapplied as before. The treatment must be repeat-

ed daily until all suppuration ceases.

After that twice, or even once, a week is often enough to repeat the application. The dry powder must be applied to the ear for two or three weeks after all suppuration has ceased. This is the treatment of uncomplicated otorrhœa in a nut shell, and the result is nearly always very satisfactory. I have the common acid rubbed in a mortar till it assumes a granulated form, like granulated sugar, and use it in preference to the minuter powder of different forms, because it goes down to the bottom of the meatus easier and does not hang to the walls so persistently as the fine powder.—*Canada Med. Rec.*

**PRURITUS VULVA.**—Martineau (*Annales Medico-Chirurgicales*) notes that this arises sometimes in the course of affections unconnected with the vulva, at others during the evolution of a disorder or lesion of this part. In the first class are intestinal worms, the oxyuris in particular; these wander at night over the neighborhood of the anus and genital organs. They should always be looked for there and then, especially in children, where there is an absence of any direct cause. Tinea tonsurans and the pediculus pubis are other causes. Affections of the Bladder, vegetations, and polypi of the urethra may lead to it. Glycosuria, also, either temporary in wet nurses, those who take much sugar, or premanent, as in diabetes. In the second category may be ranged pruritus, consecutive to various primary or secondary inflammations of the vulva, which may be simply local, or proceed from a general diathetic or constitutional cause, as tuberculosis, eczema, herpes, psoriasis, lichen, epithelioma. Vulva pruritus may be purely nervous, and then appears without any manifest lesions of the mucous membrane or skin; at times it may be associated with articularia. The diabetetic form is best treated with the effervescent citrate of lithia, with addition of a little arseniate of soda. Locally, during the acute stage, lotions of bromide of potassium or of chloral are recommended, and in the chronic phases a weak solution of corrosive sublimate and alcohol.—*Edinburgh Medical Journal.*

**HYDROCHLORATE OF COCAINE IN THE VOMITING OF PREGNANCY.**—Weiss, of Prague, has used this remedy successfully in cases of vomiting in pregnancy which had resisted all previous attempts at relief. The patient was weak and anemic, of a certain disposition, and had suffered in three previous pregnancies from persistent vomiting; in the present pregnancy her condition was serious.

Weiss prescribed:

R Hydrochlorate of cocaine gr. ij;  
Alcohol, enough to dissolve.

Water..... 3 v.

S: One teaspoonful every half hour.

After the sixth dose three tablespoonfuls of milk were well borne; after the eighth, a cup of broth with egg, without vomiting. After the sixteenth dose the patient ate with relish chicken broth, slices of white chicken meat, and drank a glass of wine, without vomiting. The drug was then withdrawn for a time, owing to an increased frequency of pulse and respiration; but hourly doses were subsequently given, with the result of entirely checking the vomiting and enabling the patient to regain her former strength.—*Edinburgh Medical Journal.*

**INTRAVENOUS INJECTION OF SALT SOLUTIONS.**—Dr. F. B. Harrington has tabulated all the recorded cases of transfusion with salt solutions. He recommends that the solution be made as follows; Sodii chloridi, 6 grammes; sodii bicarbonatis, 1 gramme; aquæ destillatæ, 1,000 grammes. The solution should be warmed and kept at a temperature between 100° F. and 104° F. The solution should enter the circulation at a low pressure, and its effect on the heart should be carefully watched. Gravity pressure is safer than a syringe, an elevation of from one-half to three feet being sufficient. The amount used would depend upon the effect upon the circulation, but it may be from one to four pints.—*Boston Medical and Surgical Journal.*

**NITRITE OF AMYL AS AN ANTIDOTE FOR OPIUM.**—*L'Union Médicale* reports the case of a person who took two ounces of laudanum, and showed every symptom of opium-poisoning—coma, small pulse,



feeble and infrequent respiration (six to the minute), coldness and cyanosis. Belladonna proved useless, while inhalation of nitrite of amyl immediately improved and ultimately restored the patient.—*Medical Record*.

DISINFECTION OF HANDS.—Kümmel,\* of Hamburg, has performed an elaborate series of experiments to ascertain the best method of making a surgeon's hands absolutely aseptic. He found that contact with soiled dressings, or at autopsies, rendered this result more difficult. Sublimate, one-tenth per cent., was inefficient. The following conditions are necessary for satisfactory disinfection of hands:

(1) Five minutes' vigorous or thorough scrubbing with brush, soap, and water, as hot as can be borne.

(2) A thorough two minutes' brushing of the hands in freshly-prepared officinal chlorine water or carbolic solution, five per cent.

In operating, the fore arm should be cleaned, as well as the hand.—*Boston Med. and Surg. Journal*.

THE PREVENTION OF INSANITY.—In a paper recently read before the Connecticut Medical Society, Dr. Gustavus Eliot presents the following conclusions, which, although they have no claim to the merit of novelty, are none the less important:

In order to prevent the occurrence of insanity it is necessary

I. To avoid the transmission of a hereditary tendency thereto, by discouraging marriage between persons of like tendencies in this direction.

II. In persons with a hereditary or acquired tendency in this direction, to counteract the tendency as far as possible.

1. By insuring regularly an adequate amount of sleep, and a sufficient quantity and variety of nutritious food.

2. By securing recreation and relaxation.

3. By maintaining the action of the secretory and excretory organs.

4. By avoiding entirely the use of alcohol and other cerebral stimulants.

5. By cultivating habits of self-control.

6. By encouraging objectivity rather than subjectivity of thought, breadth, and not narrowness of mental activity.

7. By avoiding anxiety and excessive mental exertion.

8. By taking disappointments philosophically, forgetting them quickly, and not brooding over the unpleasant occurrences of the past, but anticipating with cheerfulness the events of the future.—*Med. Times*.

THE DANGER OF SYNCOPE IN HOT BATHS.—It is surprising, says the *Lancet* (July 3), that deaths by syncope during the use of hot baths are not more common than the coroner's court returns would show them to be. The peril of faintness by the mere determination of blood to the surface of the body, thus quickly depriving the heart of its usual normal support and stimulus, is very great. In cases of muscular weakness of the heart this danger must be imminent whenever the "hot" or even the "warm" bath is used. Apart from this obvious risk, however, there is always the possibility that in weakly or too impressionable states of the nervous system the peripheral stimulation produced by the application of heat to the whole of the cutaneous extremities of the afferent nerves may so act on the centres as to arrest the evolution of energy by an inhibitory influence. It is doubtful whether we lay enough stress on this consideration when prescribing the use of such external agents as act on large areas of surface and strongly impress the nerves there commencing. We know how burns of even moderate severity may kill by the impression they produce on the centres of vitality from the periphery. There is much to learn in regard to the nature and extent of the central effects which may be thus caused. Whether for good or evil, the application of heat or cold to the whole surface is a potent measure, and one that ought not to be recklessly resorted to, more especially in cases of great susceptibility, involving such excitability of the nervous centres as often co-exists with fairly good health in a weakly body.

\*Centralblatt f. Chirurg., April 24, 1886.

ERRATA.—In the article on "Aural Reflex Phenomena," by Dr. J. G. Wiltshire the following errors occur: On page 381, 1st column 7th line read *of* before *phenomena*.

In 24th line, 7th word, read *deducing*.

In 28th line, read *transmute it* for *transmitted*.

In 2nd column, 1st line, read "*superior cilio-spinal*."

On page 382, 1st column, 6th line, read *parent nerve* for *joint nerve*.

In 17th line, read *Nussbaumer*.

In 51st line, read *teeth* for *tooth*.

In 2nd column, 12th line, read *where* for *when*.

In 34th line, read *teeth* for *tooth*.

### Medical Items.

The Roman Holy Office has issued a decree forbidding Roman Catholics to belong to cremation societies, and the practice of cremation is stigmatized as *detestabilem abusum corpora humani cremandi*.

The treasurer of the Dundee Royal Infirmary recently received a donation of £100 from a grateful patient, in return for treatment received by the latter while he was an inmate of the Old Infirmary in the year 1843.

In the last five years Billroth has performed operations on the stomach in thirty-two cases, with nineteen fatal results. Out of fifteen gastrectomies for cancer, there were seven recoveries.—*Boston Med. and Surg. Jour.*

The *N. Y. Medical Journal* announces that Dr. Oliver Wendell Holmes will read a poem on the occasion of the celebration of the 250th Anniversary of the Harvard University, which is to be held on the 6th, 7th, and 8th of November.

Dr. Thomas A. McBride, a well-known physician of New York city, died on board the steamship *Aller* at sea, on August 31st. He had been abroad in search of health. The cause of death was kidney disease. Dr. McBride was born in Ohio, but has resided in New York since his graduation. He was forty years of age.

The Paris Academy of Medicine is reported to have announced the follow remarkable subject for a prize essay: "*Préciser par une série d'observations s'il existe un traitement abortif de la syphilis confirmée*." To abort a confirmed syphilis appears to be as encouraging a task as the proverbial locking of the stable door after the steed is stolen.—*Boston Med. and Surg. Jour.*

Professor von Langenbeck has been suffering for some time from failing vision due to a cataract. He recently submitted to an operation for its removal at the hands of Dr. Pagenstecher, of Weisbaden. The operation was entirely successful. Many friends, including the Emperor and Empress of Germany, have sent telegrams of congratulation to the eminent surgeon.—*Med. Rec.*

Upon the occasion of the recent celebration of the five hundredth anniversary of the University of Heidelberg, the honorary degree of Doctor of Medicine was conferred upon Prof. Bell, of Washington; Professor Chevreul, of Paris; Baron Nordenskjöld, of Stockholm; Sir William Thompson, of Glasgow; Professor Roscoe, of Manchester, and others. Professor Koch, of Berlin, was created Doctor of Philosophy.—*Med. Record.*

The *Medical News* says: "A Montreal man lately sued a druggist for damages for having been deprived of work for several weeks in consequence of taking poison sold him by mistake. The error was caused by the wholesaler, who had labelled the package wrongly before selling it the druggist. The court held, however, that the druggist should have verified the contents of the package, and gave judgment for two hundred dollars and costs."

Dr. Broca, the eminent anthropologist, is the author of a formula relative to the height and weight of the human body. It is that the body should weigh as many kilogrammes as it measures in centimetres, after deduction of the first metre. Thus, a man measuring one metre eighty centimetres should weigh eighty kilos. Should his weight be more or less, he is too stout or too thin. As men grow older they lose weight, but as a compensation they diminish in height also.

The eleventh annual session of the American Gynecological Society will meet in the Hopkin's Hall, in this city, on Tuesday, September 21st. The meeting will be held under the Presidency of Dr. T. A. Reamy, of Cincinnati. On the evening of the 21st the Society will be entertained at the Hotel Rennett by the Baltimore Gynecological and Obstetrical Society. Entertainments will also be given by Drs. W. T. Howard, H. P. C. Wilson and B. B. Browne, of this city, resident members. The address of welcome will be delivered on Tuesday, by Dr. H. P. C. Wilson. The profession of this city is invited to attend the sessions of the Society.

During the late war, at a period when the success of the Union cause was pretty well assured, President Lincoln was invited by some distinguished engineers of the army to inspect a plan which had been drawn for a very elaborate and expensive system of defence for the City of Washington. After examining the drawings attentively he inquired what was the necessity for the works. "The defence of the capital," was the reply, "in the contingency of a Confederate invasion." The president thereupon was reminded of a story of a debating society of a Western town, where the question was discussed "Why does a man have breasts?" Several nights of debate failed to elucidate the problem until the matter was submitted to a referee who decided "that if under any circumstances, however fortuitous, or by any chance or freak, no matter of what nature or by what cause, a man should have a baby, there might be breasts to nurse it."—*Boston Med. and Surg. Jour.*



## Selected Articles.

## REMARKS ON THE GENERAL TREATMENT AND DRESSING OF WOUNDS.\*

BY JAMES WHITSON, M.D., F.F.P.S.G., F.R.M.S.

Assistant Surgeon to the Glasgow Royal Infirmary.

During the last few years the treatment and dressing of wounds have undergone a marked change for the better. The introduction of the antiseptic system has led to improvements in both these ways which long ago were undreamt of. Prior to this great epoch in surgery, wounds of any magnitude were daily to be seen discharging large quantities of pus, and at brief intervals epidemics of pyæmia decimated the wards of hospitals in a manner truly alarming. Under an antiseptic régime, however, these complications have been banished as if by the enchanter's wand, and at the present time suppuration is a factor with which we seldom require to deal, while pyæmia and hospital gangrene are scourges almost unknown. To all who were familiar with the difficulties surrounding the early elucidation of the subject, it need scarcely be remarked that the realization of such a degree of excellence has not been achieved at a single bound. On the contrary, the standpoint now held by antiseptic surgery has only been attained after years of toil and as a result of much wearisome labor, for scientific research of permanent value is invariably a plant of tardy growth, and even under propitious circumstances can only reach maturity by degrees. Like all other departures from an old routine, the antiseptic system had many prejudices to overcome, and in its initial stages may be said to have been evolved slowly out of a perfect chaos of disorder. Those who were Sir Joseph Lister's pupils during the time he held office in the Glasgow Royal Infirmary will recollect that his first attempts to prevent putrefaction in wounds were exceedingly rude, but gradually under the light of

increasing experience the methods pursued by this eminent surgeon became more perfect, though the principle as at first laid down by Lemaire remains unshaken to the present hour: "The wound which suppurates, as I hope to demonstrate presently, is a secreting surface, the products of which become altered under the influence of air, and give birth to a series of phenomena due to one and the same cause—fermentation."

If decomposition arises in a wound, the processes of repair become disturbed, nutrition is interfered with, and a condition of septicæmia of more or less pronounced type is necessarily established. Fortunately for patient as well as for surgeon complications identical with those just described can be obviated by a rigorous adherence to antiseptic laws. In addition to the destruction and subsequent exclusion of the various forms of organisms constantly present in the atmosphere, and which find in the living tissues a congenial habitat, there are a number of other points attention to which is essential for the successful progress of wounds generally. Prominent among these are arrest of bleeding and drainage. Blood when effused into a wound cavity should be permitted a ready exit, because when retained it clots in a comparatively short time, and with the transformation from the fluid to the solid condition all chance of future escape short of opening up the flaps is frustrated. If small the clot may be absorbed and thus prove of no consequence, but if present in excess a mass of this kind assumes the characters of a foreign body, and unless removed will speedily give rise to irritation. Hence the danger arising from the confinement of much effused blood, and consequently there stands out all the more prominently the need for the prevention of such a complication by the thorough arrest of hæmorrhage in wounds prior to the suturing of their edges. A little time spent in securing the different bloodvessels will amply repay the original outlay.

In carrying out excisions, it is a good plan to pack the fresh wound firmly with green protective and rolls of gauze

\*From *The Lancet*, Sept. 4th, 1886.

dusted with iodoform.\* The layer of protective should be inserted first.† By placing it next the tissues no débris of gauze is permitted access to the wound, and owing to its smooth, non-adherent surface, there is at the same time the additional advantage that when we remove the stuffing—which is best done forty-eight hours after the operation—the whole of it comes away easily in a body. By the end of this time all hæmorrhage has usually ceased, the steady compression exercised on the divided bloodvessels during the interval being in the great majority of instances sufficient to occlude the mouths, and the edges can then be approximated without trouble.

A dependent system of drainage is what we ought to aim at. Blood, so long as it remains fluid, obeys the ordinary law of gravity by seeking its lowest level; consequently, the lower the aperture for its passage outwards, the greater the area operated upon and the more complete the evacuation. Drainage may be carried out either with aid of the indiarubber tubes of Chassaignac or by means of the decalcified chicken-bone tubes of Macewen. For recent wounds the latter are preferred to those of indiarubber, and if threaded with hair the principle of capillarity is called into play and a syphon action induced.‡ Hair has, however, the disadvantage of not draining pus, and where suppuration exists indiarubber tubes should be used.

The suturing of wounds demands care and attention. Dragging of the stitches is a complication which must be carefully guarded against, and if tension on the margins of the flaps supervene, inflammation of the surrounding parts will certainly follow unless the strain be promptly relieved. In order to avoid

this and secure immediate union of the edges, we frequently make use of button sutures, and in excisions generally they are valuable auxiliaries in the conduct of the case.

The proper dressing of a wound is indispensable for its satisfactory progress. Unless in those instances where the discharge has become septic, dressings should be removed as seldom as possible, absolute rest being a *sine quâ non* for the progress of healthy repair. In the carrying out of this important item our great aim should be the selection of a dressing in which are united a capacity for ready absorption and a subsequent power of maintaining the parts in a state of asepticity. Fortunately we have at our disposal materials answering these requirements more or less completely. Of the various dressing which are placed in contact with the skin, there are none. *cæteris paribus*, superior to gauze. Being porous, it permits of the ready penetration of blood or serum through its meshes, and when properly prepared and in fresh condition its antiseptic powers are undoubted. Eucalyptus gauze is preferable to the carbolized variety, though at present it possesses the drawback of being the more expensive of the two. Owing to the volatile nature of antiseptic principles, both kinds of gauze should be placed in air-tight boxes as soon as saturation is effected. By this means evaporation of their essential constituents is prevented. For a number of years after the introduction of the antiseptic system layers of gauze surrounded by an outer layer of jaconet composed the dressing placed over a wound; but in following what was then the ordinary custom, experience soon showed, if there was much oozing, as there frequently is after major operations, that stains quickly made their appearance at the lower end of the dressing, thus necessitating its frequent removal, and thereby forcing us to adopt a most objectionable practice. In order to obviate this alternative, recourse can be had to layers of carbolised tow, which when thoroughly teased form an excellent supplementary dressing. The compression exercised by rolls of this mater-

\*In excisions of the elbow-joint this is best done prior to the removal of the elastic bandage.

†The protective plaster will answer the purpose best if perforated. When this precaution is taken, any effused blood speedily finds its way through the perforations into the gauze, and is thus removed *in toto* along with the stuffing.

‡The hair is best removed at the end of forty-eight hours, as all serous or sanguineous discharge has usually ceased by that time; but when the dressing is intended to remain on for some weeks, this adjunct should be dispensed with.



ial is regular and steady, and owing to the elastic nature of these when enveloping a limb the circulation is unlikely to be interfered with, even though the bandages are put on somewhat tightly. Any discharge which happens to pass outside the gauze is taken up by the tow and in consequence of the impregnation of its fibres with carbolic acid a state of asepticity is maintained for a much longer time than could be done without it, and repeated changes of dressing are thus rendered unnecessary. Of late, however, tow, and to a considerable extent gauze, have come to be superseded by wood-wool as well as by wood-wool wadding, two forms of external dressing not without special merits. Both possess considerable absorbent power,\* and when made into pads of the requisite size and thickness do admirably to envelop the first two or three layers of gauze. In the preparation of the wood-wool pads care should be taken to see that the wool is properly distributed throughout, so that the pressure which is afterwards brought to bear on the underlying structures may be equable.† It will be found for example that wood-wool is superior to tow in checking any tendency to oozing immediately after an amputation by the regular compression which it exercises over and for some distance around the stump, while the immobility which its presence confers is a factor in furthering the after-progress of repair, which should not be lost sight of. When a dressing is intended to remain for some time, it is advisable to adopt the precaution of dusting the gauze and wood-wool we purpose employing with iodoform. The powder in question is a reliable germicide, and corroboration of this property has been frequently witnessed in several of the wards of the Glasgow Royal Infirmary, where a species of fungus used regularly to develop itself in the gauze which was

at one time supplied, but it was always noticed that the organisms never appeared or encroached upon the area sprinkled with iodoform—a test which clearly proved the value of the compound in checking the spread of such a form of life. The elastic bandage is a valuable agent in the treatment of wounds of any size. When properly applied, it maintains the dressing firmly in its place, and by so doing ensures the keeping up of steady compression—points which contribute in no slight degree to promote the general weal.

The ideal wound may be defined as one which heals with a single dressing. In Dr. Macewen's wards during the past year not a few amputations of limbs, as well as excisions of mammae, have only received a primary dressing, and when looked at for the first time at the end of three weeks were found to be healed.\* In all these, decalcified drainage-tubes without hair were used, and on the removal of the first dressing the whole extent of the tubes were found to have been consumed by the tissues, with the exception of the small portions or ends protruding from the lips of the wounds, and which on inspection were seen to be lying loose on the layer of gauze placed next the skin. It is obvious, therefore, that in aseptic cases, where we can maintain the dressing without change for several weeks, decalcified drainage-tubes are superior to those of indiarubber, from the fact that they leave no sinus behind, and after their first insertion require no further notice to be taken of them.

It is almost unnecessary to add that perfection in surgery, as in other pursuits, cannot be attained without the expenditure of much time and labor. In all the cases referred to the greatest pains were taken to secure the whole of the divided bloodvessels.‡ The stitches were carefully and regularly inserted, so that there was no dragging on the edges of the flaps. A thorough system of drainage was established, and by

\*Wood-wool and wood-wool wadding take up blood or serum readily, but neither absorb pus well, and where suppuration is going on the dressings require to be frequently changed.

†After the wood-wool is placed within the bag of gauze which holds it together, threads may be passed through the pads at regular intervals and secured on either side by means of buttons. If this arrangement is followed, shifting and consequently lumping of the wool are prevented.

\*The last sixteen amputations of limbs and the last five excisions of the breast have healed with a single dressing.

‡In the amputations of the limbs the greater number of the arteries were tied before the removal of the elastic bandage, so that this class of operations may be described as practically bloodless.

means of suitable dressings the parts were maintained in a state of asepticity and at absolute rest. Finally, the temperatures (taken twice daily in the rectum) were examined at every visit, with the view of detecting and rectifying the slightest departure from the normal order of things.

### INFANT FEEDING.\*

BY E. PAGET THURSTAN, M.D., CANTAB.

This is a question of great interest to every medical man, and one on which the last word has not yet been said, I think. On the ground that the salivary and pancreatic secretions are hardly present in a new-born child, it is always stated in books that food of a farinaceous nature should be avoided entirely in arranging the dietary of very young children who require to be brought up by hand. In theory this is true; in practice it is not. Owing to the mechanical difference in the nature of the curds of human and cow's milk, there is probably always some difficulty for children in digesting cow's milk, while in some cases it is very great. This difficulty is generally recognized, and the usual explanation given is that the milk is too rapidly curdled, and sets into a single hard mass, to which the digestive agents can get no access. Fermentation proceeds too far, and the result is either vomiting of large masses of curds, or constipation, the motions also consisting mainly of undigested curd with marblings of green and yellow. I quite agree with this theory, but I do not agree with the usual mode of treatment advised.

It is generally recommended, if the milk curdles (1) to add lime-water; (2) to add barley-water; (3) to add dilute concoctions of linseed; (4) to employ solution of isinglass; (5) to use cream and water, excluding the curd; (6) to abandon milk altogether, and use veal-tea, beef-tea, or well-skimmed mutton-broth. This last plan is of great service, when in hot weather acid fermentation is quickly developed, or when

alarming vomiting and gastritis occur; but it is obviously only a temporary expedient. As regards the other plans, the favorite and almost routine treatment is the lime-water plan. Now, lime-water, so far as my experience goes, sometimes *produces* sickness; and, any way, it cannot be right to give *medicine* daily for months if there be any reasonable alternative, for what we want in these cases is a diet which can be given for months together without producing indigestion. Of the other plans enumerated above, the cream-and-water diet, seems to be excluded by the fact that the curd alone possesses the nitrogenous casein which is necessary for perfect nutrition. The problem we have to solve is how to make the curd digestible; to exclude it altogether is to cut the Gordian knot.

The preparations of barley, linseed, or isinglass are not open to the above objections, but there are practical difficulties in the way of preparing them suitably in sufficiently small quantities at a time. The theory on which the use of these is founded is that in children with excessive secretion of gastric acid the milk can be prevented from curdling too rapidly by adding something to thicken the milk and entangle the curds as they form. This theory is plausible, and, to my mind, explains the facts fairly well. On this view the function of the barley-water or isinglass is mainly, if not entirely mechanical. If so, why not allow a small amount of farinaceous food on the same ground? I have accepted the logical deduction from this reasoning in my practice, and I feel sure that no diet produces so uniformly good a result as milk thickened with farinaceous food of some kind. The crust of bread (when free from alum and large quantities of potato starch), Brighton biscuit, or one or other of the well-known infants' foods may be used, but only in very small quantities, so that the milk can still be sucked through the tube of a feeding-bottle. I do not think it much matters which "food" is used, as I believe that when given in this way in early life its function is mainly mechanical—viz., that the par-

\*From *The Lancet*, September 4, 1886.



ticles of solid entangle the curds as they form, and prevent them from coalescing into one large mass. It must be borne in mind that many people hold the view that this tendency of cow's milk to form masses is not due to any excessive acidity in the child's stomach, but to a provision of nature, whereby the calf is able to regurgitate the milk and ruminate. I do not know whether it is a fact that calves chew the curd as their mothers do the cud, but it is certainly the case that the condition of acidity in the child has something to do with it, for it is a known fact that the offspring of gouty and rheumatic parents have more trouble in the way of digestion than the, in other respects, more delicate infants of scrofulous or tuberculous parents.

It has been proposed to overcome the difficulty of digestion by preparing milk with pepsine and pancreatine. Now this plan seems to me objectionable. Nature's revenge on all parasites is to deprive them of the organs which they refuse to exercise. If we habitually rear children without putting them to the necessity of digesting their food for themselves, we ought not to be surprised if we finally evolve a race of beings totally without digestive functions of any kind! Short of this extreme view, the tendency does not seem a wise one.

Finally, we ought perhaps to consider the claims of condensed milk. That the curd of this milk is more digestible than the curd of most forms in which milk is taken is, to my mind, indisputable. A new drawback, however, makes its appearance. Condensed milk is, in plain English, milk jam, and the excess of cane sugar produces indigestion in a new way, while moreover, the condensation seems to deprive the milk of much of its saline constituents, and removes material required for bone formation.

We are forced back, then, to the farinaceous foods in very small quantities, added to cow's milk and water, as being the best artificial diet for children. The vendors of the various foods for infants lay great stress on the fact that the starch of the wheat has undergone some chemical change which renders it easier for digestion. This may be true to some

extent; the diastase, when present, may convert a portion of the starch, but this (in the early weeks of life, at all events) is probably a secondary function. The following case which has recently occurred in my practice will illustrate my views, and, I think, confirm their correctness:

The wife of a well-to-do tradesman was prematurely confined of a female child nine weeks before she was expecting; the presentation was breech and footling. When the child was born, it was cyanosed and made no attempt to breathe. After performing artificial respiration for five minutes the breathing became fairly established; but the child was still cyanosed, and did not cry. I cut the cord and bled the child to two drachms, after which it cried fairly strongly. The mother had never been able to nurse her children, and no attempt to do so was made now. It was fed on milk and water, half and half of each. The weather being hot, we had no difficulty of keeping up the warmth of the child, and for a few days all went well, except that the child could not be induced to drink more than half a pint of milk daily. Three days after birth it weighed 3 lb. 8 oz. A week later it weighed 3 lb 9½ oz. In the meantime the cord and the surrounding rag had come away, so that the actual gain could not have been more than an ounce, probably less. Shortly after this, sickness and slight diarrhoea came on. Veal-tea was ordered with the milk, and cream-and-water twice a day, instead of entire milk-and-water. Some powders were given, containing a third of a grain of mercury and chalk, with a little aromatic confection, ipecacuanha, and rhubarb. The diarrhoea and sickness abated, but the child was still taking very little. Eight to ten drops of brandy were added to the milk three times daily. At the end of another week the weight was 3 lb. 10 oz., being a gain of only ½ oz. The child was now fed on milk, thickened with a little patent farinaceous food. The following week the weight was 4 lb., the gain being 4 oz. The week after the weight was 4 lb. 9½ oz., being a gain of 9½ oz. The child is now doing well.

Here is surely a clear case of a life preserved by a change of diet, and a change, too, from a diet which we may call orthodox to one that is often spoken of as absolutely injurious.

### Society Reports.

#### CHICAGO GYNÆCOLOGICAL SOCIETY.

REGULAR MEETING HELD JULY 16, 1886.

The Vice-President, HENRY T. BYFORD, M.D., in the chair.

DISCUSSION OF DR. F. E. WAXHAM'S PAPER  
ON OCCLUSION OF THE OS UTERI AS AN  
IMPEDIMENT TO LABOR, WITH A  
REPORT OF TWO CASES.\*

Dr. W. W. Jaggard said: From the very clear description of Dr. Waxham's case, I infer the condition was that described by Nägele under the term, *conglutinatio orificii*, an uncommon complication of labor, but seldom indicating incision. Usually, pressure of the finger is sufficient to open the os.

A more serious condition is that described by Schmidt. under the term *conglutinatio organica*. The cervical canal is obliterated to a variable extent. I had a case, illustrating this condition, under my observation in Professor Spaethe's wards during the winter of 1882. The lower half of the cervical canal was obliterated. Radical incisions were made around the *os externum*, and the canal was dilated with the index finger. Forceps were subsequently applied. The case was reported in the *Medical News*.

Dr. John Bartlett said: I have nothing of interest to offer directly pertinent to the present discussion. But I have rather recently attended a case which I deem so nearly akin to those reported by Dr. Waxham as to justify me in mentioning it.

Mrs. Anderson, 37 years old came under my notice about three years ago. Five years since, she felt a burning pain in the nose and about the womb. At

the same time her menstruation increased in quantity until in the course of a year, it became profuse. Because of these difficulties she sought relief from a quack. For the purpose of removing a cancer, which this pretender diagnosed, a most violent caustic was put into the nostrils and applied to the womb. One year afterwards the tissues injured by the corrosive had healed; a violent uterine pain remained, and the flow had again become excessive. She applied to Dr. A. R. Jackson, who made an operation for the relief of the *atresia vaginae* which he found existing. Although the operation was thorough, contraction recurred; so that when she was admitted into the woman's Hospital in 1883, her condition was probably about the same as it was prior to Dr. Jackson's treatment. Dr. Mary H. Thompson operated upon the patient, opening thoroughly to the *os uteri*. Contractions, however, very soon reformed in the vagina; in October, 1885, her condition was serious. Her pulse was weak and frequent; neuralgic pains about the pelvis was nearly constant, and superadded to these older symptoms were those suggesting pregnancy. The uterus was enlarged and menstruation had ceased for three months. Of her condition at that time, Dr. Thompson writes: "The vagina was closed more perfectly than before. Not an opening could be seen in the occluding disc, which was only one inch from the *ostium vaginae*. By examination through the rectum, it was ascertained that the uterus was enlarged, especially toward one side of the body." The distress of the patient, the apparently complete closure of the vagina, the nonappearance of the menses and the peculiar enlargement of the womb suggested either retained menstrual blood or some form of pregnancy. After a consultation, Dr. Thompson proceeded to open up the canal—at the time supposed to be perfectly occluded—between the uterus and vaginal *cul-de-sac*. In reality, a very small opening still existed; this was enlarged carefully by incision and distension until the *os uteri* was thought to be easily in communication with the remains of the vagina.

\*Read at the May meeting.



One month after the operation I was called upon to visit the patient. On the preceding night at a certain hour, most violent pains, as those of childbearing, had come on, and had continued despite of anodynes, for some five hours. The pains had now at the same hour as the night before, returned with increased violence. Not to go into details, I will say that the symptoms pointed strongly to some form of pregnancy. In view of the serious character of the case, I called in consultation on the next day, Dr. R. G. Bogue. We left the patient still in doubt as to her true condition. During the following night I was again summoned; the exact resemblance of the pains to those of labor, and the now recognized hardening of the swelling above the pubes during these pains, made it quite certain that pregnancy existed, and that the contractions would finally lead to the extrusion of the foetus from its *sac per vias naturales*, or otherwise. Upon careful examination, the vagina was found to be shut off about one inch from the *ostium* by a hard, firm and thick disc of cicatricial tissue. Toward one circumference the small opening detected and enlarged by Dr. Thompson a month before was recognized. By rectal examination, what seemed to be the *cervix uteri* was reached, three quarters of an inch beyond the upper face of the cicatricial disc. Connecting the disc and cervix was apparently a tube of tissue much smaller in circumference and thinner than proper vaginal walls. The pains continuing with regularity, Dr. Bogue and myself concluded to assist delivery. Slight incisions by means of the bistoury were made in the circumference of the opening in the cicatricial disc, a metallic dilator was then introduced, and when some dilatation had been effected, a modified Barnes dilator of very small size was inserted. Within an hour, by the occasional use of the knife and the continual tension of dilators, the disc opening admitted for a little distance the end of the finger into the remnant of the vaginal tube, above the disc. By the point of the finger pressed firmly onward, could now be recognized a hard body which was taken

for the *cervix uteri*. With a little more dilatation of the disc opening, it was perceived that the hard body was the foetus, and that the *os uteri* was healthy and dilating in a normal manner, the membranes being unruptured. As soon as the opposing disc opening was expanded to a size presumed to be sufficient to permit of the passage of the head, the membranes were ruptured. It was then discovered that the shoulders presented; by aid of suitable instruments the child was turned and in the somewhat too vigorous efforts at delivery the body parted from the head, the latter remaining *in utero*. This accident in such a case, with an extra, entirely rigid *os* precluding free procedure through the *os uteri*, ordinarily would be regarded as unfortunate, I looked upon it as a favorable step toward delivery, confident that by means of a suitable vectis the head could be easily scooped through both of the opposing ora. In fact, the head was readily so delivered, and the placenta falling over the *os uteri* was removed with the same instrument. One of the symptoms that confused the diagnosis on the first day of the appearance of labor pains was the unusually large, rapidly attained size of the supra-pubic tumor. This symptom was now explained, for an examination to determine if the patient was entirely "cleared" revealed the presence of a second foetus presenting by the head. The vectis was applied and the foetus at once withdrawn, as was also in like manner the second placenta.

The labor revealed the true anatomy of the injured parts. The patient desired that the passage through the disc should be kept open, but inasmuch as the *os uteri* was almost immediately behind it, it was deemed useless and harmful to make the attempt. Within three months the dilated opening in the disc had contracted to a size but little greater than that observed before the miscarriage.

Dr. F. E. Waxham said: I would simply allude to the great resemblance in the case coming under my care, between the uterine tissue and the foetal membranes, especially in those cases in

which there is but a small amount of amniotic fluid, and I can see how very easy it would be to do permanent injury to the mother by rupturing the uterine tissue by a pencil or some other sharp-pointed instrument, when, perhaps, by more extended and careful examination, it would be found that simple dilation would be sufficient. In the case reported, the knowledge that the amniotic fluid had been escaping for several hours was sufficient evidence to me that there was an os, and it was also proof that the tissues presenting were not membranes, but the uterine tissue. But the great trouble was to discover the os, and I assure you, it was difficult indeed. The os was present in the center of the presenting mass, and yet we could not discover it. It was impossible for me to do so, and it was only after a continued, careful and searching examination that Dr. Nelson was enabled to detect the very slight dimple which was present.

DISCUSSION OF DR. HENRY T. BYFORD'S  
PAPER, ENTITLED "A STUDY OF THE  
CAUSE AND TREATMENT OF PEL-  
VIC HÆMATOCELES."\*

*Dr. T. D. Fitch* said: I have had very limited experience with operative procedure in this class of cases. As a rule, I feel like praising the bridge that has carried me safely over. My usual treatment has been the expectant plan, or trusting to reabsorption of the clot. Reabsorption occurs in other tissues of the body, the leg or arm, where you would not think of opening the cavity and turning out the clot. It would be a very bad principle in surgery, I think. My experience has not been sufficient to condemn the operation entirely, but I feel like trusting to the safer plan of the expectant treatment. I have never operated in more than two or three cases, and would not have operated in them had there not been a mistake in diagnosis. One of these cases was a lady at Jefferson, who gave a history of cellulitis. There was softening and fluctuation in the tumor presenting. I was

called in consultation by the attending physician. The symptoms were those of cellulitis, resulting in abscess. The aspirator was used and a very small amount of pus was drawn off, and then a larger amount of disintegrated blood. All was drawn off that could be, and the woman recovered, no bad results following the aspiration. No drainage was instituted, and no scooping out of blood clots was performed; there was no special treatment except on general principles, and the vaginal injections of antiseptic fluids. The opening was not enlarged, the sac was not injected, nor washed out. The opening made by the aspirator needle probably closed up so that no air was admitted, and no decomposition or blood-poisoning occurred.

Another case was one in which I assisted in an operation for supposed extra-uterine pregnancy. Two distinguished Fellows of this Society were present and concurred in the diagnosis. It was then decided to open the tumor through the vagina with the galvano-cautery knife, and when this was opened, there poured out of it a gelatinous fluid, as white and as clear and pure as could be; it looked to me very much like soft boiled rice. It was a clear white, and perfectly inodorous. The sac was washed out with antiseptic fluids, and the patient treated on general principles; I think no drainage was used. The sac was not scooped out; nothing was turned out except the tablespoonful or two of gelatinous fluid, of which I spoke.

Another case I might mention, in which the attending physician and myself (I was called in consultation) diagnosed an abscess; opened it with the aspirator, and found that it was an hæmatocele. I believe the expectant plan of treatment is preferable to operative interference. I think a larger percentage of cases would recover under this treatment.

*Dr. John Bartlett* said: I will take occasion to refer to a fatal accident that once came under my observation, which tends to show the necessity for the greatest care in opening cavities, *per vaginam*, whether resulting from hæmatocele or cellulitis. A patient was greatly

\*Read at the June meeting.



reduced by long continued pelvic abscesses. It seemed to be one of those cases in which an operator is called upon to make a determined attempt to reach, evacuate and curette a chain of abscesses found to exist within the pelvis. Several collections of matter were opened, and it was supposed that the object of the operative procedure had been happily accomplished. The final washing of the cavity with carbolized water was in progress when suddenly, the patient fell into a profound collapse, respiration ceasing and pulsation at the wrist failing. This condition was regarded as an accident from ether. Every effort at restoration was unavailing till a Faradic current was passed through the phrenic nerves at proper respiratory intervals. The patient then gradually rallied, and the danger was thought to have ceased. On the following morning the carbolized injection was repeated by an assistant; a fatal collapse immediately ensued. Post-mortem examination revealed a small opening through the roof of the pelvis, and the presence in the peritoneal cavity of the injected fluid. If the Society will pardon a digression, before closing I will take occasion to refer to a symptom of hæmatocele, which would seem to be as rare as it is suggestive. In one case, associated with this condition, I observed the whole surface of the abdomen below the navel, to present an ecchymotic appearance as from the extravasation of blood after an injury. The patient was alarmed at the "black and blue" appearance, regarding it as a sign of "mortification." It existed for weeks and disappeared, *pari passu*, with the pelvic extravasation.

Dr. W. W. Jaggard thought the ruptured cyst of extra-uterine pregnancy a more frequent cause of retro-uterine hæmatocele than the text-books would lead one to believe. Gallard has emphasized the importance of the operation of this etiological factor. He\* makes a statement to the effect that independently of traumatism, almost all hæmatoceles are caused by the ruptured

cyst of extra-uterine pregnancy. Such a broad statement naturally provoked salutary criticism. More recently, Veit,† of Berlin, has collected 146 cases of hæmatocele, of which forty cases, or 28 per centum were probably due to the ruptured cyst of ectopic gestation. Veit's estimate does not appear extravagant.

He would like to inquire of the author of the paper, what was the indication in the case reported for operative interference? The indication had probably been stated, but through inattention, he did not remember it. A small non-suppurating, retro-uterine hæmatocele of six months' standing was not, *per se*, an indication for any operative interference.

Any discussion of the surgical treatment of retro-uterine hæmatoceles, would be incomplete without some mention of Dr. A. Martin's plan of treatment in cases of extra-peritoneal hæmatoma. Laparotomy is performed, eventeration of the intestines effected, the sac incised, evacuated and curetted, and subsequently united by sutures; drainage is maintained *per vaginam*. In Martin's hands, this operation has been perfectly successful in six cases.

Dr. C. T. Parkes said: "I do not think I have anything new to offer on the question of treatment of hæmatocele. My experience embraces only three cases. The first was a lady whom Dr. Fitch saw with me about a week after the initial symptoms, which present themselves in these troubles, had appeared, and we concluded to make an opening through the *cul-de-sac* of Douglas. I used the Paquelin cautery for the purpose of opening up the mass, which was not very extensive. The principal symptom which led us to think it was necessary to resort to interference, was the evidence of the presence of probable suppuration. The lady had been having slight chills and some corresponding rise of temperature, and we thought it best to be certain whether or no the mass had decomposed and broken down, so we opened it with the cautery, and quite a quantity of grumous, broken

\*Leçons Cliniques des Maladies des Femmes. Paris, 1873. P. 635.

†Die Eileiterschwangerschaft. Stuttgart, 1884, P. 14.

down blood, with clots, came out. The lady was relieved of her pain and distress. We introduced a drainage tube, and through this tube passed a large catheter as long as the opening would permit; and washed out the cavity every day and followed it up for a long while, with a diminution in the size of the mass, until it got so that it was merely perceptible above the pubes, then the chills came on again more severely, and after suffering for a month or six weeks she finally died of septicæmia. In that case I was satisfied from the fact of being able to fill the cavity apparently, under the force of hydrostatic pressure, and then have something give way, and the fluid rapidly disappear, that we had a series of cavities which were opening into each other. I think if I had such a case to manage now I should do differently. I should use thorough antiseptic precautions, and care at present; such treatment was not then deemed necessary. The next case, a very interesting one, happened last winter; I saw the lady four or five weeks after she was taken ill. She was taken as though she were going to have a miscarriage after having missed menstruation twice, and when I saw her she was in an extreme condition of collapse; upon examining the abdomen, it was found full of something, dull on percussion, resonant above, and to the sides; on digital examination the ordinary signs of hæmatocele were present. This woman was in such a weak condition that I could not bring myself to the idea of interfering, and tried to support her and wait for events. I attended her two weeks, while she varied from one condition to another, all the time life hanging by a thread. In the third week, on examining her abdomen, I thought I detected fluctuation, and in two or three days was certain of it. I aspirated in the *linea alba* midway between umbilicus and pubes, and at first withdrew a quart of blood, but, although I was satisfied there was more there, I did not repeat the aspiration that day. Two days afterwards I aspirated again, and withdrew two quarts. She began to improve from that moment; I merely put her on tonics and supporting treat-

ment; this was in February. I saw her about a month ago, and she was going about the house the same as any one else. The third case was a little later in the same year, a lady who had been bleeding a little for some time, with the presence of signs of conception of two months' date. I made an examination, and was satisfied that I detected to the right of the uterus a mass as large as one's fist, easily reached by manipulation internally and externally, tense to the touch, and elastic. I diagnosed a probable hæmatocele, kept her quietly in bed, but did nothing special for her. The occurrence of this tumor was accompanied by extreme shock, prostration, pallor of the body and symptoms of collapse. She has now entirely recovered without any interference whatever. That case led me to think of some of the reports I have read about surgeons being called to see a patient in collapse, finding she has flowed a little, with a history of probable pregnancy, making an examination, and discovering a little tumor, diagnosing extra-uterine pregnancy, using electricity and curing the patient. It seems to me there may be a possibility of there being a mistake in some of these cases of extra-uterine pregnancy that are cured so readily by the use of electricity. They are becoming very frequent. I must say, that it was a very difficult matter for me to decide in this case, whether it was extra-uterine foetation or hæmatocele, still I am satisfied that it was an hæmatocele.

*Dr. H. T. Byford* said: Before closing the discussion I would like to add the following case to the series reported in the paper.

*Case VI.*—Mary H., a German servant girl, 25 years old, was taken sick with pains about the lower abdomen, nine months ago. The attack, which came on after a menstrual period, kept her in bed little of the time, but did not pass off. In six weeks her menses came on and lasted two weeks. The bleeding ceased for a few days, then returned and had continued, in varying quantity, until stopped by ergot about a week before I saw her. Vesical irritation was an almost constant symptom. Up to that



time, she had tried to attend to her work, but then gave up her place. She told me, a little over a month ago, when I first saw her, that she had felt worse since taking the medicine. The great pelvic tenderness subsided rapidly under the "absolute rest" treatment, and in less than a week afterwards, I was able, without paining her, to completely circumdigitate a large boggy or semi-elastic tumor in the right broad ligament, extending behind the uterus from a level with the internal os upwards, and reaching into the left broad ligament, where it felt harder and nodulated. The uterus was anteflexed, displaced anteriorly, and to the left (leaving only room enough between the cervix and the pubes for the index finger) and intimately attached to the surrounding mass. The probe entered three inches, turning forwards. After keeping off her feet, although not in bed, using hot douches, iodine applications to the abdomen, iron internally, and having glycerine plugs applied about every three days for three weeks, the tumor had become harder, somewhat nodulated in places, and perceptibly smaller. She had felt quite well again until the last few days, when she undertook to resume her domestic duties.

This case shows well the positive benefit of rest, and the positive harm that is sure to result from want of it. Its history is similar to the history of many such tumors which go on to suppuration, but which, with proper treatment, would have been promptly absorbed.

The unfortunate case related by Dr. Bartlett bears witness to the dangers of the curette in pelvic hæmatoceles, and is probably one among many somewhat similar ones that have not been reported. The necessity of a large opening, perfect drainage and great antiseptic precaution is vividly shown by one of the cases recited by Dr. Parkes. His view as to the liability to the formation of pus pockets is corroborated by the sudden discharge of half an ounce or more of pus on March 26, in the case of Mary St. —, followed by the rapid sinking of the uterus back into a natural position. This

pus pocket, had the operation *not* been performed, would probably have formed and pointed upwards in the direction of the least resistance, and would have become an abdominal abscess, and a serious thing to manage. I quite agree with Dr. Parkes that simple hæmatoma and hæmatocele are too often thought to result from extra-uterine pregnancy, and think it is partly the result of Gallard's theory that all non-traumatic cases are extra-uterine pregnancies, a theory which has done its good and has had its days. The intensity and persistence of the local symptoms, the passage of the decidua, and the past or present characteristic symptoms of the pregnant condition should usually prevent such a mistake.

I think with Dr. Jaggard that Bandl would have us operate too early; I only claimed that Bandl's views were a great advance in the therapeutics of pelvic effusions, in that, while recognizing the dangers of early interference, he does not allow the fear of inducing septicemia to intimidate him into waiting until septicemia has already accomplished its mischievous, and perhaps fatal work. The reason why Bandl's latest views have had so little apparent effect upon the profession, is that they have only been before the profession at large for a few months. I had come to the conclusion that with our present knowledge of antiseptics we need not be frightened out of opening up these accumulations, and had acted upon it, before I knew of Bandl's views; and so had many others whose veneration for long established authority had not overpowered their individual judgment.

A. Martin's method of operating for hæmatoceles and hæmatoma, is *one* method, but that it is *the* method cannot be maintained upon scientific grounds so as to convince the profession; nor has it as yet been so proved by its success. As to the frequent bunglesomeness of operations *per vaginam* and *per rectum*, there is scarcely to be found an opportunity for the bungler like the performance of laparotomy for pelvic disease. I doubt if I exaggerate in saying that half of the abdominal sections are done in a bungling manner, especially when com-

pared to those of Martin and a few others.

In my paper I advocate the expectant plan of treatment, and have used it, and, so far succeeded with it, in all of this series of cases except one. That case was operated upon because the conditions for a cure without an operation were not attainable; because even if attainable, they would have taken too much time to restore the patient to usefulness, and because if properly done, the operation in such a case is almost devoid of danger. I regard it as a good illustration of when we may operate in case the expectant plan does not afford relief. In case VI, Mary H., which I have just reported, I shall use every effort to do without surgical interference, because the interior of the sac cannot be easily and safely reached.

Protheroe Smith, M.D., M.R.C.P., of London, was then elected Honorary Fellow of the Society.

W. W. JAGGARD, M.D., *Editor*.

## THE AMERICAN GYNÆCOLOGICAL SOCIETY.

THE ELEVENTH ANNUAL MEETING HELD  
IN HOPKINS' HALL, JOHNS HOPKINS  
UNIVERSITY, BALTIMORE, MD.,  
SEPT. 21, 22, AND 23, 1886.

### *Tuesday, Morning Session.*

The Society was called to order by the President, Dr. T. A. REAMY, of Cincinnati.

Dr. H. P. C. Wilson, of Baltimore, delivered the address of welcome.

In the name of the resident fellows, of the general profession, of the citizens of Baltimore, and in the name of her women, he extended to the Society a hearty welcome. Where our hands as big as our hearts, the speaker said, we should kill you with kindness. "Baltimore is ever ready and willing to welcome you whenever you are ready to come. I can assure you of the great interest which this community takes in the subjects of your deliberations."

Dr. H. P. C. Wilson, of Baltimore,

read the first paper, which was entitled

### THE DIVISION OF THE CERVIX BACKWARDS IN SOME FORMS OF ANTE-FLEXION OF THE UTERUS WITH DYSMENORRHOEA AND STERILITY.

This operation, which is an old one, has been substituted by the use of stems, spongetents and dilators, but he had found no measure so safe and efficient as the knife, in the classes of cases to which he called attention.

The cases in which he recommended the operation were

First. Those of ante flexion of the uterus, with a hard indurated cervix, where the body is bent upon the neck, or the neck upon the body, forming a more or less acute angle.

Second. Those cases of acute flexion where the cervix is hyperplastic and indurated and dense as cartilage.

Third. Those cases where there is a hard, unyielding internal os, through which the probe passes with difficulty, and in its passage gives the sensation of passing over rough, dense cartilage, while the finger in the sulcus between the body and the neck in front, gives the impression of a strong cord tied around the uterus. In a typical case calling for the knife all these lesions co-exist. Nearly all these cases are sterile. The posterior lip is then divided with scissors up to the vaginal junction. An uterotome is next passed and the internal os divided anteriorly and posteriorly to an extent sufficient to permit the introduction of a large sound. The parts are allowed to bleed freely. A pledget of cotton soaked in a mixture of Monsel's solution, iodine and glycerine, is then introduced into the cervix, and over this, pledgets treated with Monsel's solution and water, and the vagina lightly tamponed. These are not removed until the third day. All manipulation of the uterus is avoided for at least two weeks. A sound is then carefully passed, and every second day the os is gently stretched with a steel dilator. The patient is allowed to fully recover from the operation, which usually



requires one month. Local treatment is then suspended for one month to allow the intra-uterine mucous membrane to improve. The patient then returns and applications of Churchill's tincture of iodine are made to the endometrium two or three times a week. The treatment after the lapse of a month is again suspended to be resumed in the course of one or two months. If this after-treatment is not carefully and properly carried out, the operation had better not be done. The speaker had performed the operation four hundred times, and had never obtained as good results from any other methods. In no case has he had a death which could be attributed directly to the operation. If the patient is not disturbed by meddlesome after-treatment for ten days subsequent to the operation, there is not much danger of inflammatory troubles.

## DISCUSSION.

*Dr. T. A. Emmet*, of New York, said that we must separate dysmenorrhœa and sterility as being due to widely different causes. Mechanical dysmenorrhœa, he believes, does not exist. We must also separate two conditions of flexion, one a flexure of the neck—a congenital defect—and the other a flexure of the body of the uterus due to preceding inflammation outside of the uterus. Sterility, resulting from this latter cause, is not relieved by the operation, and its performance is attended with great risks to life. The congenital flexion is the only one in which we operate to relieve the sterility. In performing the operation he recommended that the vaginal mucous membrane be drawn to the bottom of the wound and secured with stitches.

*Dr. James R. Chadwick*, of Boston, regarded the flexion as always congenital, the result of the persistence of the infantile shape of the uterus. This want of development, he thought, of the organ also involved the function. The effect probably extends to other portions of the genital tract. He thought that the operation should be restricted to those cases in which there is flexion with a small external os, but in which the uterus seems to be well developed in other respects.

*Dr. W. H. Baker*, of Boston, said that while the immediate results of the operation were very gratifying, yet in many cases the patients did not retain these good results. He limited the operation to the class of cases in which there is a congenital malformation, and those in which there has been an inflammatory condition, the results of which have been removed. The good results which *Dr. Wilson* reports must be explained by the great care in the after treatment which he practices.

*Dr. Fordyce Barker*, of New York, remarked that some 30 years ago he employed the operation in a few cases, but soon gave it up. The only cases in which he now employs it, is where the narrowing is at the os externum.

*Dr. J. Scott*, of California, has gradually come to limit the operation to the cases described by previous speakers. After the operation, the patient should be confined to bed at perfect rest and hot water injections be employed every two hours.

*Dr. W. T. Howard*, of Baltimore, said that his experience had not shown him that any particular operation is the one for all cases. By the antero-posterior incision he had obtained some excellent results. With the precautions adopted in operating in other portions of the body an incision of this kind in the majority of cases should not be dangerous. *Dr. Mundé*, in a paper on this subject, reports over three thousand cases with only nine deaths. In some cases he employed the posterior incision, in others the bilateral incision, but in the majority of cases he dilates, using antiseptic precautions, and never taking less than twenty to thirty minutes to complete the operation.

*Dr. H. P. C. Wilson*, of Baltimore, had not heard anything in the discussion to convince him that in properly selected cases, division of the cervix is not the best thing to do. As he had already said, if the operation is not followed by proper after-treatment, it had better not be done. The danger is not from the operation itself, but from the improper after-treatment.

*Dr. B. Stansbury Sutton*, of Pittsburg, read a paper on

ANOTHER MODIFICATION OF EMMET'S CERVIX OPERATION WITH A CASE IN POINT.

A case of old standing neglected double laceration of the cervix was reported. The cervix was composed of dense, hard hyperplastic tissue, almost cartilaginous in character. An operation by the ordinary method, was out of the question, for the sutures would not have held. In order to remove the greatest amount of cicatricial tissue and overcome the conditions, the following procedure was resorted to. The lower lip of the laceration was denuded of its altered mucous membrane, leaving only a narrow strip, corresponding to one-half of the strip usually left to serve for the future os. The upper lip was treated in the same way, leaving the opposite half of the strip of mucous membrane. When the flaps were brought together, the strips of mucous membrane lay side by side with the undenuded surface of one flap in apposition with the denuded surface of the opposite flap. In this way union in the position of the future canal was prevented. Good union followed the operation and at the end of three weeks a Simpson sound was passed without difficulty.

DISCUSSION.

*Dr. Thomas A. Emmet*, of New York, remarked in such cases where there has been such cystic degeneration it is often better surgery to remove a portion of the cervix, so as to get into healthier tissue. In a certain number of cases, he had always performed amputation.

I use the term in the sense in which it is employed by the Germans. If we remove the tissue to a depth below the follicles, the remaining dense tissue will gradually soften.

*Dr. George J. Englemann*, of St. Louis, had found no difficulty in preventing union and had paid very little attention to the strip of mucous membrane. In such cases as have been described by Dr. Sutton, he had cut away nearly all the mucous membrane and inserted a short piece of fine cat gut. This keeps all the opening which is necessary. In such extreme cases he thought it better to resort to partial am-

putation as is performed in Germany.

*Dr. W. H. Baker*, of Boston, held that if we can restore the healthy character of the strip of mucous membrane and retain it, that is the best surgery. In this class of cases he had been in the habit of removing a transverse wedge shaped portion of each lip of the cervix and then bringing the parts together. In this way the hyperplastic tissue preventing the apposition of the surfaces is removed. If proper preparatory treatment is employed, the saving of the strip of mucous membrane can usually be accomplished.

*Dr. R. Stansbury Sutton*, of Pittsburgh, remarked that in the case described there was only one of two things to be done, either to remove the cervix or devise some new method of operating. This modification gave complete satisfaction in this case and he purposed trying it in other similar cases.

The following paper was read by the Secretary:

NOTES ON THE TREATMENT OF RECENT LACERATION OF THE CERVIX UTERI.  
BY DR. ELWOOD WILSON,  
OF PHILADELPHIA.

Occasionally a tear of the cervix can be recognized immediately after labor, but sometimes this can not be done. The patient should always be examined ten or twelve days later. If laceration be found immediately after labor, injections of corrosive sublimate solutions, one to five thousand, with the insertion of an iodoform suppository should be resorted to. The vagina should be irrigated every day and the suppository, renewed. When the laceration is found within three weeks after delivery, the following treatment should be employed. After the surface has been carefully cleansed and dried, it should be painted with a solution of nitrate of silver, one drachm to the ounce of distilled water. From three to five applications at intervals of five days are usually required. In every case in which the author had tried this measure (six in number) the result was entirely satisfactory.

The discussion was participated in by Drs. Barker, Emmet and Scott.

*To be Continued.*



## MARYLAND MEDICAL JOURNAL

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BALTIMORE, SEPTEMBER 25, 1886.

**Editorial.**

THE ABOLITION OF CRANIOTOMY.—One of the most striking evidences of the improvement in obstetric practice during recent years is found in the growing infrequency of the operation of craniotomy, and in the substitution for this procedure of other methods which permit of the birth of living children without an increase of maternal mortality. The frequency with which craniotomy has been practiced in non-catholic countries has been justly denounced as a stain upon midwifery practice. The theory that the infant's life is of minor value to that of its mother, however just and rational it may appear from a moral and social standpoint, has undoubtedly led to the unnecessary practice of craniotomy in many instances, and it is an auspicious era in the history of obstetric science when greater consideration is shown to methods of procedure which tend to do away with this sacrifice of infantile life. The tendency of scientific growth is to perfect all methods which have in view the good of the human race. This is illustrated most happily in the growing aim now made to abolish the operation of craniotomy. Whether this aim will ever be fully reached is at present more than we dare hope, but it is satisfactory to note the rapid progress made in this direction. The various substitutes for craniotomy have been markedly perfected within the last half century; additions are being constantly made to the technique of these infant-

saving procedures which are annually diminishing the number of craniotomies for living children. Tyler Smith, who was an earnest opponent of craniotomy, some years ago pointed out the fact that this operation was almost always performed for some condition of pelvic distortion, and he claimed that as the latter was a preventable disease, we could hope, from measures which improved the sanitary surroundings of young girls, to diminish the number of pelvic distortions. The Factory Act, which has been in force in England for some time, by limiting the age at which young girls could be employed in the workshops, has already done much to lessen the frequency of pelvic malformations in that country. In Germany, where no such law is in operation, the greater prevalence of pelvic distortions is observed. In our own country we know of no such legislation as that which is in force in England. Pelvic malformations in this country have been fortunately far less frequently observed than in England, but in view of the greater demand made upon American girls for employment in factories within the past quarter of a century an increased number of malformed pelvis may possibly be observed among the present generation of women. It is quite evident that where safeguards have been adopted the operation of craniotomy has been less employed. The first step then in the abolition of craniotomy has been made in the removal of those causes which induce distorted pelvis among the working classes of women.

Craniotomy has been resorted to in two classes of cases; first, where the head failed to engage in the pelvic brim, and second in cases where the head was delayed in the pelvic cavity. In the first class of cases the perforator has been regarded as justifiable, but it is now a debatable question whether delivery may not take place in these cases by milder methods. We have as substitutes for perforation, premature delivery, version and high forceps. Each one of these procedures has been simplified and improved within recent years, and if skillfully employed may aid in introducing

the viable infant into the world even in those cases where perforation was almost in positive demand. The successful application of either of the above measures demands a careful survey of the pelvic distortion, both as to its extent, variety and inclination. Premature delivery necessitates an early examination and study of the pelvic lesion.

It may therefore be affirmed as a rule of action that primiparæ should be examined prior to the seventh month for pelvic distortions. Whilst this law is not in universal force its observance would greatly simplify the conduct of labor. In the case of the multipara the previous history of labor is an indication of her future conduct under the same ordeal.

In the second class of cases, detention in the pelvic cavity is met by forceps delivery. The greater perfection of the modern instrument, and increased skill in its use admit of deliveries in cases in which craniotomy was formerly demanded. Where the distortion at the pelvic outlet is so marked as to defeat the use of the forceps, premature delivery or embryotomy are clearly indicated. Here a knowledge of the pelvic lesion in advance of full term is of invaluable service in determining the rule of action.

Whilst in minor pelvic lesions the substitution of premature delivery, version or forceps has obviated the necessity for craniotomy in many cases in which it was formerly the chief resort, in extreme cases of contraction its substitutes have worked marked improvement in saving infantile life. The question now under discussion in cases of extreme pelvic distortion is whether embryotomy, Cæsarian section, or Porro's method shall be adopted. As statistics accumulate the advantages of these different procedures occupy a conspicuous position in the discussions of the present day. There are advocates for each procedure who warmly champion the individual merits of each. Where the pelvis is known to be impassible the advisability of an early abortion in lieu of Cæsarian section at full term does not seem to us to admit of discussion. The former is certainly preferable though it necessi-

tates a practice from which every true obstetrician will shrink, especially when it is repeatedly demanded in any one given case. The Porro operation has peculiar advantages to some who have advocated it, in that it removes the patient from all danger of subsequent childbearing. The results of the Porro procedure, and its modifications, have been most striking and have so modified the practice of the obstetric art as to revolutionize its entire relation to the method of delivery by abdominal section. Prior to the adoption of the Porro method Cæsarian section was the most unpromising of all abdominal operations. The contrast of the Porro results with the old classical section explained as never before the defects in the latter procedure and pointed the way to modifications in the technique of this method which to-day bring the Cæsarian operation into conspicuous prominence. When once the causes of maternal death are removed from the Cæsarian section it deservedly comes to the front as the most rational and humane of all methods of delivery in extremely contracted pelvis. This is what has been done by Sænger and his followers. Having overcome the dangers of the uterine section by methods of closure which prevent leakage, Dr. Sænger has solved the problem of maternal death from the Cæsarian operation, and in the light of present results deserves to rank as the originator of one of the most conspicuous life-saving operations of this age. To R. P. Harris, of Philadelphia, the profession is indebted for the latest statistics of the Sænger Cæsarian section. Dr. Harris reports (*Med. News*, September 18th, 1886) ten additional cases to the twenty-eight Sænger operations previously repeated by him, making thirty-eight in all, of which thirty-three are European, and fourteen belong to the current year. Of these fourteen, twelve were saved, and probably all of the children, but certainly thirteen, the fate of one not having been mentioned. The thirty-three European operations saved twenty-six women and thirty-one children. The percentage of women saved in all countries was 68½, whilst the percentage of



women saved in Europe alone was 78.

In the United States the operation has been performed five times with five deaths of mothers and three of children. Dr. Harris says, "It will be seen that our position is not at all creditable to us as a nation. Standing second in point of numbers, we are least in respect of success, both in the proportion of women and children saved."

To do better in the future, Dr. Harris suggests that we must make the operation one of choice, not one of compulsion. In this statement we find an explanation for the large mortality of the Cæsarian operation in its past history. It has been the last resort after the failure of other procedures, such as version, forceps, and craniotomy, and has been undertaken when the life of the patient had been worn out by expedients and delays which rendered the operation absolutely hopeless when undertaken. "In a case of pelvic obstruction, first carefully determine the working space, do this early in labor, and then operate, if the space measures so small that Cæsarian section will at the last be a necessity of delivery." By the observance of such a law as this, the obstetrician may hope to raise his art to the highest standard of success, and may be the means of saving infantile and maternal life to an extent formerly despaired of. Craniotomy is a procedure which is indirect violation of human and divine law; whilst it may not be possible to abolish it absolutely, it is surely on the decline and must sooner or later yield to more humane measures.

THE ANNUAL MEETING OF THE AMERICAN GYNÆCOLOGICAL SOCIETY. — Six years ago the American Gynæcological Society held its annual session in this city. This meeting was pleasantly remembered by those members of the profession here who were especially interested in this branch of scientific work. The mere presence of a distinguished scientific organization in actual work in our midst tended to encourage and strengthen the aims of those gentlemen who were already engaged, or were about to engage, in this special work. As an

outcome of this meeting the Obstetrical and Gynæcological fields have been more sedulously cultivated by the profession of our city, and results have followed which have given definite shape to our local work in the form of a local organization having the same objects in view as the national society.

During the present week the Eleventh Annual Session of the American Gynæcological Society has been conducted in our city and the profession here is again indebted to this society for its agreeable presence and stimulating influence. We speak for our local profession when we say that we have been glad to welcome this distinguished body of scientific workers to our city. The meeting has been one of advantage to us from a scientific standpoint, whilst its social features have been of the most cordial character.

The present meeting, whilst not so large in point of members, has been marked for its zeal and interest. The usual number of papers were read, and the discussions following the same have been earnest and animated. Among the subjects presented for consideration, not a few of them have an important interest in professional consideration at the present day. The recent advances in abdominal surgery and the tendency which now exists to run to extremes in this branch of surgical work have called forth an earnest discussion from the membership of the society. Between the lines of thought presented by the different speakers we see evidences of a judicious conservatism which appear as signals of caution along the precipitous highway that the abdominal surgeon is now travelling. An earnest protest has been offered against the adoption of operative procedures which, to say the least, do not yet occupy the plane of rational methods.

We witness in the annual work of the Society a growth of the scientific spirit and a gradual liberation from the dominion of empirical views and practices. However widely gynæcological practice may have strayed in the past from the path of rationalism in many of its methods and principles, it approaches to-day

a position in the domain of scientific work which is creditable alike to its scientific development, and to the zeal and labor of those who have elevated it by their investigations to this position. To the growth of the science of gynecology the American Gynecological Society has contributed largely. Its annual deliberations have been watched by the profession at large with practical interest. It occupies in our own country the commanding position among all of those organizations which are working out the problems which effect woman's physical well-being. To the alleviation of human distress it has contributed much, and we bespeak for it continued usefulness in this direction.

THE MEDICAL COLLEGE OF THE STATE OF SOUTH CAROLINA IN NEED OF ASSISTANCE.—Among the ruins of Charleston, S. C., brought about by the earthquake of August 31st, the buildings belonging to the Medical College of the State of South Carolina are so wrecked that the Faculty of this school have felt constrained to appeal to members of the profession to aid them in repairing the damages sustained.

The walls of the college building have parted, and the roof will have to be reconstructed before the building can be occupied. It is estimated that it will take \$5,000 to make the necessary repairs.

The College itself is without means, and its Faculty have been so crippled by their individual losses that without outside assistance the work of repair cannot go on. The profession throughout the country are requested to contribute to the aid of the College. Contributions for this purpose should be forwarded to Dr. F. Peyre Porcher, of Charleston, S. C.

DEATH OF DR. JAMES G. WAKLEY.—*The Lancet* (Sept. 4) announces the death of Dr. James G. Wakley, who for twenty-five years was the editor and proprietor of this publication. Dr. Wakley was the youngest son of Mr. Thomas Wakley, the able and courageous founder of *The Lancet*, and suc-

ceeded his father in the conduct of this journal upon the death of the latter some years ago. The son proved a worthy successor of the father, and through many years of hard labor succeeded in raising *The Lancet* to the first place among the medical journals of the world. Dr. James Wakley is represented by *The Lancet* as a man of simple and retiring manners, but an earnest and untiring worker in whatever cause his interests were aroused. He aimed to make *The Lancet* not only an exponent of the best medical thought of the day, but an agency for good in correcting and exposing medical abuses and public evils. He gave his whole life to the conduct of this work, which stands to-day a noble monument to the industry, talent and skill of Thomas and James G. Wakley, father and son. Dr. Wakley died on August 30, from epithelioma of the tongue.

### Miscellany.

CONCEPTION OF MALE CHILDREN AT THE TIME OF THE POST-MENSTRUAL ANÆMIA. Dr. Camillo Fürst, of Graz, publishes in the *Archiv. für Gynæcologie*, 1886, xxviii, 1, p. 14, a contribution to the interesting and frequently-discussed question, When and how is the sex of the conception-product determined? In the first section of the paper, which treats of "the time and causes of the determination of the sex in general," Fürst proposes certain maxims which, though not new, will interest our readers. According to the author we find a surplus of male conceptions in the working classes and country inhabitants as compared with the well-to-do people and the inhabitants of cities. Likewise, we can look for the surplus of male infants during hard times and the concomitant rise of food-prices, and before the ultimate extinction of a race. If a deficient nutrition of the procreators produces a surplus of male children, our author continues to argue, we can be certain that also the state of nutrition of the fecundated ovum, especially shortly after conception, will influence the sexual differenti-



ation. And as after menstruation the vessels of the genital organs assume an ischæmatus character—forming the so-called post-menstrual anæmia—Fürst concludes that conceptions taking place immediately or shortly after menstruation will give a surplus of males on account of a relatively bad nutrition of the fecundated ovum. To strengthen his theory the author utilizes the statements of women confined in maternities, who mostly with an astonishing certainty could remember the end of the last menstruation and the day of conception. The statistics of the mentioned institutions show a very considerable surplus of male children for the first four or five days following menstruation, and a surplus of female ones for the succeeding period.—*Ther. Gaz.*

**A MIXTURE FOR GASTRO-INTESTINAL ATONY.**—The following formula is given in "Nouveaux remèdes" (quoted in "Union médicale du Canada," January, 1886):

Tincture of nux vomica, . . . . .	2 parts ;
Fluid extract of <i>Cascara sagrada</i> , 20 "	
Syrup,	
Cherry-laurel water, { each . . .	15 "
Distilled water, . . . . .	10 "

Three or four teaspoonfuls to be taken daily.—*N. Y. Med. Journal.*

**A RUSSIAN OINTMENT FOR ARTICULAR RHEUMATISM.**—Grinevitski ("Brit and Col. Druggist," July 24, 1886) is credited with this formula :

Extract of aconite, . . . . .	$\frac{1}{2}$ drachm ;
Mercury ointment, . . . . .	1 "
Hyoscyamus ointment, . . . . .	$\frac{1}{2}$ "

**TEREBENE LOZENGES.**—Hurty (*Ibid.*) suggests the following :

Terebene, . . . . .	$3\frac{1}{2}$ drachms ;
Gum arabic, . . . . .	3 "
Water, . . . . .	2 ounces ;
Powdered sugar, . . . . .	.6 "
Powdered tragacanth, . . . . .	.2 "

Make 100 lozenges.—*N. Y. Med. Journal.*

**PARENCHYMATOUS INJECTIONS OF QUININE IN AGUE CAKE.**—Professor F. Fazio relates in the *Rivista Clinica e Tera-*

*peutica* for July, 1886, the case of a woman, thirty years of age, who had suffered from malarial fever, and who had also marked hypertrophy of the spleen. The tumor extended from behind the margin of the ribs to a line drawn on a level with the anterior superior spine of the ilium. It was determined to attempt a reduction in the size of the spleen by means of parenchymatous injections of quinine. The instrument used was the ordinary hypodermic syringe provided with a longer and thicker needle than usual. The bisulphate of quinine was employed, and thirty-two injections of each  $4\frac{1}{2}$  grains were made, care being taken to make the successive punctures at some distance from each other. The result of treatment was a reduction of over one inch in the length of the tumor. The injections were not followed by pain or by any other unpleasant symptoms. The experiment was interrupted by the departure of the patient from the hospital, but Dr. Fazio believed that the results obtained were sufficiently encouraging to warrant further trials of the method.—*Medical Record.*

**LONG-CONTINUED ALBUMINURIA.**—We once asked Dr. Johnson how long he had known a case of albuminuria to extend. He replied, thirty years. We may safely conclude that a disease which could be extended over thirty years might, with more care, extend over forty, and leave life very much uncurtailed. But this implies great care on the part of the patient and physician alike.—*Lancet.*

**MEDICAL AND SCIENTIFIC NEWSPAPERS IN JAPAN.**—From recently published statistics of the Japanese press it appears there are seven medical papers, with a monthly circulation of 13,514; nine relating to sanitary matters, with a circulation of 8,195; and two on the pharmacopœa. There are seven devoted to various branches of science.—*Exchange.*

**A REMEDY FOR CORYZA.**—Muriate of cocaine two grains, roasted coffee and white sugar, of each one ounce. To be taken as snuff.—*Med. Press,*

## Medical Items.

Leopold claims to have removed the cancerous uterus, per vaginam, thirty-eight times with but two deaths.

The next meeting of the Virginia State Medical Society will be held at Fredricksburg, Va., beginning October 26th, 1886.

The American Public Health Association will meet in Toronto, Canada, on October 5, and will continue in session four days. The meeting will be largely of an international character.

The Georgetown Medical Faculty have their new college building in Washington nearly completed, and expect to have it ready for lectures October 1st. The introductory lecture this year will be delivered by Dr. John B. Hamilton, the professor of surgery.

The German and Austrian Cremation Association will hold a congress at Gotha about the middle of September. A matter which will be specially considered is, how to overcome the opposition of the various governments who have hitherto declined to permit cremation.—*Ex.*

*The Medical Record*, of New York, has opened a subscription fund for the relief of the suffering physicians of Charleston, S. C. It is stated that the families of many physicians are still without sufficient shelter and more funds are urgently needed. Any contributions left with this JOURNAL will be promptly forwarded to the proper authorities.

A young man entered the Dispensary of the Chicago Polyclinic recently, and going up to the clerk held out one of the dispensary circulars, with the question: "Say! isn't this the hour for diseases of women?" The clerk answered in the affirmative, when the young man said: "Well! I've got a disease of a woman and want to be treated."—*Jour. of the Amer. Med. Association.*

During the recent meeting of the American Gynæcological Society its members were hospitably entertained by the profession of our city. On Tuesday, Wednesday and Thursday the Society and its invited guests were entertained at lunches given by Drs. W. T. Howard, H. P. C. Wilson and B. B. Browne. On Tuesday evening a banquet was given to the Society and its invited guests at the Hotel Rennert, by the Baltimore Gynæcological and Obstetrical Society.

The *Medical Age* says that a member of Congress from the West received the following from one of his constituents:

"Dear Sir: My children have been afflicted with scabs all winter, and the medicine given them by the doctor here does not seem to do them any good. I see by the papers that there

are some very fine doctors in Washington connected with the government, and if it does not cost too much, I wish you would ask them what is good for the scabs and write me by return mail."

Dr. Edson, of the Health Department of New York city, has been making an investigation of the milk brought to that city over the various railroads, and has found that in some instances it was diluted with as much as forty per cent. of water. Recently he made a report to the Board of Health of an inspection made by him of ten candy factories. At one of them he found a quantity of Venetian red, which is used to give color to low grade chocolates, and in another, some burnt umber, which is used in the coloring of Christmas toy candies.

Sometime before his death, Dr. Jas. G. Wakley, the well-known editor and proprietor of the *London Lancet*, made a special request that the following confession of faith should be introduced into any notice of his life which might appear in the pages of *The Lancet*: "Feeling my deep responsibility to God for the position in which, in His providence, He has placed me, I desire to testify to the comfort derived during my sickness from a living faith in Our Lord Jesus Christ, and that I die in the sure hope of a glorious resurrection."

Dr. F. Peyre Porcher, of Charleston, S. C., writes to Dr. L. A. Sayre, of New York. "You know what a peculiar position in a community we occupy; every service expected of us, and the most unselfish devotion to relieving others; while we are supposed to be endowed with the faculty of living on air." Dr. Porcher says, "The contributions to the people here have been very generous, but medical institutions and physicians derive no benefit from such." We have no doubt of the great suffering among our professional brethren and their families, and we urge those who are blessed with an abundance of this world's goods to extend a helping hand to the unfortunate members of our profession in South Carolina.

The American Gynæcological Society has elected the following officers for the ensuing year: President, Dr. A. J. C. Skene, of Brooklyn, N. Y.; Vice-Presidents, Drs. J. C. Reve, of Dayton, Ohio, and Ellwood Wilson, of Philadelphia; Secretary, Dr. J. Taber Johnston, of Washington, D. C.; Treasurer, Dr. M. D. Mann, of Buffalo, N. Y.; Members of the Council, Drs. W. H. Baker, of Boston, T. M. Drysdale, of Philadelphia, C. C. Lee, of New York, and A. R. Jackson, of Chicago. The following were elected Fellows of the Society: Drs. C. M. Green, of Boston, E. C. Dudley, of Chicago, A. F. A. King, of Washington, A. W. Johnstone, of Danville, Ky., H. Marion Sims, J. E. Janvrin, and W. Gill Wylie, of New York, and B. F. Baer, of Philadelphia. The Society will hold its next annual meeting in New York City beginning September 19th, 1887.



## Original Articles.

### PRELIMINARY NOTES ON THE STUDY OF MALARIAL BLOOD.

BY WILLIAM T. COUNCILMAN, M.D., OF  
BALTIMORE.

Owing to great number of malarial cases which have been received at Bay View during the last month, an usually good opportunity has been afforded for the study of the blood, having regard to the recent interesting discoveries which have been made in this territory of research. Examinations of the blood, both fresh and when dried, have been made. So far both the bodies of Laveran and those described by Marchiafava and Celli have been found, but in a different class of cases. One case especially seemed to be of great importance. A man was received into the hospital from one of the Eastern Shore counties apparently suffering with malaria, temperature 105°. He was at once given ten grains of quinine, with the result of an abatement of fever. An examination of his blood showed a great number of hyaline crescentic shaped bodies with a mass of pigment in the centre. The quinine was stopped and the man continued to improve under placebo treatment. Daily examinations of the blood were made and the crescents constantly found. On three occasions motile pigmented bodies were found. In order to study the effect of quinine, forty grains were given in two days with apparently no results on the condition of the blood. The motile bodies found were similar to those described by Laveran though somewhat smaller. In one case of comatose malarial fever, in which death took place one hour after admission into the hospital, the diagnosis was made by an examination of the blood immediately after death. In this case the non-motile hyaline bodies were found. Other forms than the plasmodia were found in five cases, all of them representing the severer forms of the disease, with the exception of the one case mentioned, and this was the only one in which the crescents were found. The plasmodia described by

Marchiafava and Celli are constantly found during the chill and in some cases in the interval. It is difficult to understand how all these various forms should represent different phases in the development of one and the same organism.

## Selected Articles.

### ON THE CAUSATION AND NATURE OF HYPERTROPHY OF THE PROSTATE.\*

BY REGINALD HARRISON, F.R.C.S.,

Surgeon to the Liverpool Royal Infirmary, and Lecturer on Clinical Surgery in the Victoria University.

In a previous paper I have pointed out that residual urine will be frequently found to precede physical signs of prostatic enlargement, and that this inability to empty the bladder may be traced to structural alterations in shape and imperfect power of contractility which chiefly involve the most dependent portion of the bladder area—namely, the posterior wall. From these observations I deduce that the initial lesion in enlargement of the prostate is the conversion of the latter into a kind of muscular buttress for providing against a structural incapacity in a contiguous part. I have further laid stress on the view which has been advanced by competent observers that the prostate is to be regarded essentially as a muscle, and not as a gland, in the ordinary acceptation of the term. In endeavoring to explain how it is that the prostate muscle may be brought under the influence of the same laws which seem to regulate the development of hypertrophies in other parts of the body, and which for the most part are compensating in their nature, there are many points connected with its clinical history and pathology, when enlarged, which may with advantage be referred to here.

In the examination of the bladder, both after death and in the course of surgical operation, it is impossible not to be struck with the altered relations

\*From *The Lancet*, Aug. 23, 1886.

which frequently exist between the viscus itself and its neck or outlet. In early adult life the bladder may be regarded as an abdominal rather than a pelvic organ; as years advance it gradually sinks within the pelvis, whilst still later on it will often be found to have become further depressed within the pelvic cavity. In this way I have seen a prominence given to the floor of the prostate what was really due, not to development of more prostate tissue, but to the bending back of the posterior wall of the bladder. When it is considered that the prostate is almost immovably fixed by ligaments in its position, whilst the bladder can rise or fall according to circumstances, it is not difficult to understand how this can be, and how an obstacle may be put in the way of micturition which does not necessarily involve an increase in the amount of the prostatic tissue. This mode of forming a prostatic bar may be very readily imitated. That an undue sinking of the bladder within the pelvis such as I have referred to would be likely to induce hypertrophy of the prostate as a compensating process seems to me to be not unreasonable. It is stated by Sir Henry Thompson\* "that actual hypertrophy of the prostate exists in about 34 per cent. of men at and above 60 years of age; that it produces manifest symptoms in about 15 or 16 per cent." From this it would appear that 18 per cent. are not injuriously affected by this change, a circumstance which almost seems to suggest that the majority of persons with large prostates are in some way or other benefited by them. These are illustrations where the compensation is precise. How frequently it happens in our daily practice that we come across instances of persons having very large prostates, but who are not conscious of suffering any inconvenience thereby. It is only very recently, when examining the rectum of a patient, I discovered that he had an enormous prostate, but beyond experiencing some degree of vesical irritability a few years ago he had now nothing to complain of so far as micturition was

concerned. A good idea of the amount of support that is afforded to the most dependent portion of the bladder by a large prostate may be formed by examining such a patient as I have just referred to with the finger in the rectum when he is placed in the erect position. By this means we can judge of the value—I was going to say the comfort of a large prostate to some elderly males with incompetent bladders.

But it may be urged that, though some cases of enlarged prostate appear capable of explanation on the ground that they are essentially hypertrophies in the usual acceptation of the term, there are others where such an explanation is not so apparent. In the latter category reference no doubt will be made to those instances where the prostatic mass is made up of more or less lobulated projections. These I would speak of as the upheavings of a frequently contracting muscular ring. In a muscle or part undergoing hypertrophic growth, and where the process is prompted by circumstances which are obviously liable to some degree of variation, tissue production may be excessive or become unnecessary. Such excess would naturally tend, under the contraction of the part, not only to protrude itself where the resistance was least, but to assume a more lowly organized form than that originally produced. In this way I believe these masses of more or less degenerated prostate tissue are formed, and just as there is a wide difference between the irritability of the bladder associated with the initial stage of the hypertrophying prostate and that caused by the fibrous projections of the gland just referred to, and which produce symptoms quite as irritating to the bladder as any stone, so is there a corresponding difference in the residual urine which accompanies each of these states. In a paper by Mr. Savory\* on the Relation of Partial Retention of Urine to its Decomposition within the Bladder, he points out that the mere retention of a certain quantity of changing urine, though constantly occupying the bladder, cannot be re-

\*Disease of the Prostate,

\*The Lancet, Oct. 14th, 1882.



garded as explanatory of its decomposition. Because a bladder does not completely empty itself, as in the initial stage of prostatic hypertrophy, this by no means implies that what it contains is stagnant and liable to decomposition. A constant stream, though a small one, through a standing pool of water ensures sufficient interchange to prevent putrescence or anything approaching it. So long as normal urine enters a bladder capable of expelling, though incompletely, so long will what is retained remain unchanged, provided that nothing is brought in relation with the interior of the bladder which can act the part of a foreign body. A prostate with fibrous outgrowths is positively more irritating to the interior of the bladder, more productive of cystitis and mucous exudation, than almost any calculus that can be met with. It is under these circumstances that we have a very different form of residual urine to that previously alluded to. In practice it is necessary that these distinctions should be recognized.

A few words, in conclusion, may be devoted to certain pathological conditions of the prostate as bearing upon the remarks that have been already made, and relative to its uses other than as a muscle. The only form of inflammation to which the normal prostate, so far as my experience goes, is liable, is that which primarily involves its numerous follicles; by the suppuration and coalescence of these follicles the whole area of the prostate may be converted into an abscess. Though I have known several instances in adults about the age of puberty, where the secreting portion of the prostate must in this way have been completely and permanently damaged, I cannot say that I ever knew such a suppuration followed by either sexual or procreative inability. And though the prostate may not be damaged to the same extent, in most cases of lateral lithotomy and operations of a like nature, if it were essential to procreation, we might expect to find a certain number of fairly well authenticated cases where this function was thus brought to an end. My experience of these opera-

tions, which has been tolerably large, does not furnish grounds for believing that the procreative power has been interfered with by them. That so important a function should, as it were, be made dependent on the integrity of two organs situated at a distance from each other seems on the face of it to be unlikely. It appears to me that the office of the prostate relatively to the sexual act is that referred to by Dr. Handfield Jones† in the following passage:—"These considerations furnish some ground for regarding the prostate as rather an assemblage of mucous follicles than really a distinct conglomerate gland; its part in the generative function is probably not to prepare any essential element of the fecundating fluid, but merely an appropriate viscid material, involved in which the seminal animalcules may be more securely transported on their destined route." The wide difference that exists in the pathology of the prostate and the testis seems to point, I submit to their being engaged in very different functions; the former comprehend those changes which we might expect in a part consisting of follicles embedded in muscle, whilst in the latter they are those which can only happen to a highly organised gland where everything is subservient to the secreting process. I should sum up the function of the prostate relatively to the sexual act as supplying a reaction which mechanically enables the fecundating fluid to act with greater certainty, at the same time supplying a muscular buttress against which the ejaculatory muscles of the urethra may advantageously act in the emission of the semen.

In a future communication I hope to refer to a certain clinical points arising out of the views I have expressed in connection with this subject.

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VENICE TURPENTINE IN CHRONIC POSTERIOR GONORRHEA is highly recommended by the editor of *The American Practitioner and News*. It should be given in large doses.

†The London Medical Gazette, vol. v., 1847.

## ON THE CAUSES AND PREVENTION OF FLAT-FOOT.\*

BY M. P. MAYO COLLIER,

M.S.Lond., F.R.C.S.Eng., Senior Assistant-Surgeon to the North-west London Hospital.

Some novel departures in the treatment of flat-foot have been lately brought before the profession. The fascination of novelty, and not necessity, is the mother of these inventions. The present treatment of flat-foot is founded on erroneous notions of its anatomy and causes.

It is incorrect to describe the antero-posterior arrangement of the bones of the foot as a bridge, and the astragalus as the keystone. A bridge usually has two extremities, fixed immovably, so resisting the tendency of forces from above to flatten the arch, the keystone being the highest point and centre of the convexity. Now, the arch of the foot has only one fixed point—the inner tuberosity of the os calcis; the other extremity of the arch is constantly changing its position, and moves considerably forwards when supporting the weight of the body. The astragalus cannot be likened to the keystone of a bridge, as it does not transmit equally to both extremities of the arch the weight of the body. The greater part of the weight of the body is transmitted directly through the os calcis to its inner tuberosity; only a small part, comparatively, is transmitted through the head of the astragalus and scaphoid to the anterior extremity of the arch. A glance at a vertical section of a normal foot will immediately convince one that such must be the case. The concavity on the under surface of the astragalus fits the saddle-shaped articular surface on the upper aspect of the os calcis accurately, permitting no gliding movement forwards, but only a rotation of the astragalus inwards on the sustentaculum tali as an axis. A movement forwards of the astragalus on the os calcis in the normal position of the foot is impossible, as the sustentaculum tali fits into the concavity

between the two articular facets on the under aspect of the astragalus. A movement forwards is impossible when the sole of the foot is resting on a horizontal surface. As proof (if need be) of this assertion, in the normal position of the os calcis the astragalus, being unconnected by ligaments or other structures, will support any appropriately arranged weight, without slipping forwards or becoming displaced.

In the light of these facts, it is perfectly evident that the chief cause of "flat-foot" cannot be due, as stated by most authors, to "a general want of tone in the fibrous structures of the body." The plantar fascia and ligaments maintain the normal position of the os calcis, and these in their efforts are assisted by the tendons passing under the lesser process of the os calcis. Ligaments are only capable of bearing a certain strain, and when continually stretched will atrophy and yield. They yield because they are over-strained first; they perform their function satisfactorily as long as they have their normal duty to perform. They do not grow weak or atonic first, and then stretch, but after being unduly strained they then grow weak and stretch. I wish to point out and maintain that the flattening of the foot is not due primarily to weakness and laxity of the ligaments, but to an antecedent alteration in the position of the os calcis. I have stated that the os calcis is capable, in its normal position, of supporting the astragalus and any reasonable superimposed weight, without the intervention or necessity of ligaments or other bonds of union. This statement holds good as long as the foot rests on a horizontal surface. If the foot rests on a surface, so that the heel is raised above the level of the toes, the weight of the body is not transmitted so directly to the posterior half of the os calcis. The saddle-shaped surface on the upper aspect of the os calcis becomes an inclined plane, sloping downwards and forwards, and, consequently, favors a sliding movement forwards of the astragalus, thus throwing the weight of the body on the calcaneo-scaphoid, interosseous, and plantar ligaments. An intermittent and occasional

\*From *The Lancet*, Sept. 4, 1886.



strain these ligaments can well stand, but a constant and continuous strain ends in atrophy, weakness, and stretching. In pointing out how constantly this cause of flat-foot is at work, we have only to reflect that each and all of us walk and stand under these abnormal conditions; the heel always being raised above the level of the sole of the foot, and with some misguided individuals to the extent of several inches. In most cases the strain is intermittent, but where constant and continuous, as in omnibus and tram-car conductors, operatives in factories, shop assistants, and others, where constant standing is necessitated, how common is this affection! Dr. Little says, "a slight degree of atonic valgus is common in girls, especially in those of the upper and middle classes; less common in boys." Why not in the less fortunate and often badly nourished females of the lower classes? Because the high heel is less prevalent in the lower than in the upper classes, and less common with men than women. For the prevention of flat-foot I would say, Don't wear a heel: let the sole of your boot be perfectly flat.

One word about treatment. It is a constant practice with surgeons in cases of flat-foot, when not too far gone—when the patient is capable of walking, although with discomfort—to order a pad of leather or other material to be placed on the inner side of the boot to support the arch. Does this support the arch? And how can it? In flat-foot the arch is destroyed. It may compress the internal plantar nerve between the pad and the head of the astragalus, and so become intolerable; but if it does not do so, it is a source of considerable comfort to the patient. Why a pad in the boot on its inner side is a source of comfort to the patient is that it belts up the anterior extremity of the os calcis, and maintains in its nearly normal position, counteracting the effect to some extent of the displacement, directing the weight of the body to the inner tuberosity of the os calcis, and removing the strain from the plantar structures. The treatment of these cases is simple when not too far advanced; good food, fresh air,

and as much rest as possible, with a radical change in the construction of the boot. The toe and heel should change places, or, what amounts to the same thing, a good laced boot should be worn, with the sole quite an inch thick in front, fining off to a line or two at the heel. By these means the normal inclination of the os calcis would be maintained, and the weight of the body properly disposed of.

### Society Reports.

#### THE AMERICAN GYNÆCOLOGICAL SOCIETY.

THE ELEVENTH ANNUAL MEETING HELD  
IN HOPKINS' HALL, JOHNS HOPKINS  
UNIVERSITY, BALTIMORE, MD.,  
SEPT. 21, 22, AND 23, 1886.

(Continued from last issue.)

#### Tuesday, Morning Session.

NOTES ON THE TREATMENT OF RECENT  
LACERATION OF THE CERVIX UTERI.

#### DISCUSSION.

*Dr. Fordyce Barker*, of New York. It seems to me that the practice recommended in the paper is better worthy of trial. It is much preferable to the rule laid down within the past few years, that if there is a laceration it should be closed immediately after labor. If this method will effect union it should be tried.

*Dr. Thomas A. Emmet*, of New York. I suppose that a certain amount of laceration occurs in every labor, but it is wonderful what nature will do restore the cervix where septic poisoning is not present. It seems too that in all cases, where under favorable circumstances, nature has failed to repair the damage there have been symptoms indicating septic inflammation. In the cases reported I believe that the same results would have been obtained even if nitrate of silver had not been employed.

*Dr. J. Scott*, of San Francisco. In only one case have I attempted to sew

up the cervix shortly after labor. In this case there was an extensive tear of the cervix and perineum. There was considerable bleeding and five hours after labor, I thought it advisable to sew up the cervix. The tissues were so soft that it was with the greatest difficulty that I could get the sutures to hold. Union took place, however, both in the cervix and in the peritoneum.

### *Afternoon Session.*

*Dr. Thomas Addis Emmet*, of New York, read a paper on

#### PELVIC INFLAMMATION, CELLULITIS VERSUS PERITONITIS.

In this country the term cellulitis has come to signify pelvic inflammation without reference to the special form, but its origin is supposed to have been in the connective tissue. So close is the relation between the connective tissue and the perineum, that it seems impossible for inflammation to be present in one without affecting the other. There are situations, however, as between the uterus and bladder, and between the uterus and rectum, where cellulitis might exist without involving the peritoneum. Inflammation in these situations tends to resolution and so the tissues soon regain their healthy condition if suppuration does not take place. After septic poisoning, the peritoneum rapidly becomes inflamed and adhesions occur. The circulation in the blood vessels becomes more or less obstructed and the action of the absorbents is greatly impeded. Finally a condition is produced which remains long after the symptoms have subsided, and one not prone to change or amenable to treatment. In such cases a fresh attack is provoked by slight causes.

It has been objected that when the abdominal cavity is opened for the removal of the ovaries, very slight evidences of inflammation are found. In a recent case, I expressed the opinion from the vaginal examination that a thickened and shortened left broad ligament would be found. At the operation no

broad ligament was found, but there was an enlarged tube lying against the side of the vagina. Similar cases have been noted. I shall explain these cases in this way. If there is an inflammation between the folds of the broad ligament, it must involve the peritoneum. As a result of the inflammation, the connective tissue disappears and adhesions of the opposing surfaces take place. The broad ligament is flattened out so that Douglas's cul-desac disappears on that side. The vaginal wall is raised up so that it and the tube lie in contact. This is the condition found by the surgeon when he operates for the removal of the diseased fallopian tubes. In all these cases I feel satisfied that there has been inflammation of the connective tissue. I think that the inflammation has been secondary to the cellulitis in every instance except where the primary inflammation was the result of gonorrhœa. If my observations are correct they would prove that the connective tissue never regains its integrity after having been once inflamed. If the surrounding tissue has restored the loss, the part will return to its normal condition. If the loss cannot be replaced nature can only repair the injury by a process of adhesive inflammation of the parts involved.

I have used the term thickening of the broad ligament, but I have not meant to imply that there is a deposit of lymph between the layers of the broad ligament. The enlargement is, I think, due to the dilated state of the veins. The condition is one easily aroused to activity.

It is still a moot question as to the way in which the tube has become involved where gonorrhœa is not the cause of the inflammation. In septic poisoning after surgical injuries, I believe that the connective tissue of the veins and lymphatics first becomes involved and that the inflammation of the peritoneum is secondary. There is no evidence to prove that the inflammation passes into the uterine canal and thence to the tubes, except in such cases where the process is due to gonorrhœa.

The prognosis as to the result to be



gained by local treatment is doubtful in those cases due to gonorrhœa, in those cases where the pelvic inflammation is of long standing without reference to the cause and in those with a history of frequently recurring attacks. In cases which can secure every attention, a cure by local treatment can sometimes be effected, but a long time is required. In cases which have to gain their own living, we may seriously consider the advisability of an operation after having gained the consent of the patient after a true representation of the operation and its results. We should enter a protest and the profession should demand a recognition of the responsibility of those who are indiscriminately operating for the removal of tubes and ovaries. While it requires an expert to determine when the operation is necessary, and still more experience and skill to do it with safety to the patient, it should only be done as a last resort after other measures have failed. In a number of cases in private practice I have succeeded in restoring the patient to health by local treatment, for whom the operation had been strongly urged. If we could get accurate statistics I think that it would be shown that the average amount of benefit gained does not compensate for the amount of risk. I believe that the operation is done too often even by those who have the least death-rate. I predict that five years will not pass before it will be almost necessary to offer an apology when this operation is proposed.

## DISCUSSION.

*Dr. Robert Battey*, of Georgia. From my experience it has seemed to me that the pelvic cellulitis which gives so much trouble was in a large proportion of these cases secondary, so far as diseases affecting this tube is concerned. I believe that if we throw out of consideration the gonorrhœal cases, the primary disease starts in the ovary. I regard most of these serous inflammations of the pelvic cellular tissue as dependent upon cystic or cirrhotic disease of the ovary.

With reference to the frequency with which this operation is done, I must con-

firm that I am largely in sympathy with the speaker. I think that the operation is done too often. I do not believe that every case of organic disease of the ovary requires operation.

In reply to question of *Dr. Fordyce Barker* asking him to state the grounds on which he would advise the removal of the tubes and ovaries, *Dr. Battey* said that every case must be determined for itself. If I had a poor miserable patient without the means of comfortable subsistence, suffering ovarian or tubular disease I would operate. If I could put such a patient under suitable surroundings and under a prolonged course of treatment, I might not think of the knife, but we have to look at the cases as they exist. I do not require in my cases an absolute diagnosis of disease of the tubes or ovaries prior to operation. It is sufficient for me to know that the general health is broken down by reason of the perverted function of her ovaries, that she is utterly miserable, that there is no reasonable hope of restoration to health by other means, and that there is a reasonable prospect of restoration by removal of the ovaries. Under such circumstances I unhesitatingly operate and contrary to my former view I do find that the ovaries are diseased.

*Dr. R. Stansbury Sutton*, of Pittsburg. I believe that when the ovary is diseased and cannot be cured by ordinary means, when it is interfering with the health of the woman and her duties in life, it should be removed. If the ovary is diseased and is a burden to the woman it is as much the duty of the surgeon to remove that ovary as it is to remove a diseased eye-ball. I agree that the operation is being done too often, not, however, by competent men, but by incompetent men.

The conditions which require the operation are not always clearly understood before the abdomen is opened. I do not believe that a man is compelled to be positively certain of what he is going to find before operating. The speaker then presented several specimens and described the cases from which they were removed.

*Dr. Busey*, of Washington. I think

that if pathologists will return to the histological basis, there will not be the difference of opinion which now exists. I believe that it is now held that the cellular tissue is really a vast lymphatic structure and that the peritoneum is a large lymphatic sac. Instead of discussing nice distinctions between pelvic cellulitis and pelvic peritonitis, it would be better to classify as pelvic lymphangitis, these different varieties.

*Dr. J. Scott*, of San Francisco. I might mention some of the cases bearing upon this point which I have seen. One was a patient supposed to have fibroid tumors. The abdomen was opened and both ovaries found to contain pus. They were removed and the patient recovered. In a second case the patient presented a tumor in the right side. The temperature record was kept for two months, during which time it did not vary half a degree. On opening the abdomen, the ovary was found to contain ten ounces of pus. The right ovary was removed, but the left appeared to be healthy and was left in position. During the operation the bladder was opened. This was sutured and the patient made a good recovery. Five weeks later the patient complained of pain in the left side and, on examination, I found an enlarged left ovary. This was removed and the patient promptly recovered. In a somewhat similar case, one ovary was removed; in a short time the other enlarged, but the operation was postponed and the woman died of rupture of the abscess.

*Dr. Matthew D. Mann*, of Buffalo. I wish to allude to the possibility of one tube and ovary being diseased without involvement of the other. There is no reason why it should be so. I have in several cases where the disease appeared to be limited to one side, removed but one ovary and the result has been a perfect cure. This operation avoids some of the objections urged against the removal of both ovaries.

*Dr. H. P. C. Wilson*, of Baltimore. I believe that where there is a general cellulitis, there is more or less pelvic peritonitis. These two affections are often associated. In the early stages, the

inflammation is often controlled by active treatment. If it is not controlled, it may go on to the formation of abscess. The pus may be discharged and the patient recover. Occasionally the abscess occurs in the tube or ovary, and these are the cases in which laparotomy is often called for. I agree that the operation is done too frequently. The point which Dr. Mann has raised that it is not always necessary to remove both ovaries is a very important one.

*Dr. John C. Reeve*, of Dayton, Ohio, read a paper on

#### A CASE OF ABDOMINAL SECTION FOR CHRONIC SUPPURATIVE PERITONITIS.

A., aged 19 years, living as if married was healthy until November last. She had never been pregnant. She was attended by a physician who found abdominal inflammation. On January 18th, she was seen in consultation by the speaker, at which time she presented evidences of chronic peritonitis, but no history of a gonorrhœal origin could be obtained. One month later she began to pass pus by the rectum. After other measures of relief had failed, laparotomy was offered in April, but declined. The patient was not again seen until June 20th, when she desired the operation. She had suffered with hectic; the menstruation had ceased since January, and examination of the urine showed no albumen. There was great tenderness and hardness all over the abdomen, pus being still passed with the stools. By vaginal examination, no definite hardness could be detected. By the rectum there was ill-defined reasonance high up on the left side. No opening into the rectum could be detected, although frequent examinations for this purpose were made. The patient was greatly emaciated, the weight having fallen from 125 pounds to 70 pounds.

The operation was performed June 23, there was great difficulty in the administration of the ether. On opening the peritoneum all the parts were matted together. The abdomen was washed out by allowing water to run into it from a pipe and then syringing out what



remained. Finally a cavity was reached in the left lumbar region. It was impossible to attach the walls of this cavity to the abdominal wound and as the condition of the patient was by this time alarming, a drainage tube was introduced and the abdominal incision was closed with sutures. In the course of several hours, the patient gradually rallied from the operation. The temperature did not go above 100. The cavity was washed out with a solution of iodine in tincture, in water. The upper two-thirds of the abdominal wound failed to unite. On the fourteenth day a large quantity of fecal matter came through the wound. This has continued to recur. In July evidences of Bright's disease were detected; since then there has been some improvement in the general health. I think that if the patient had consented to the operation when first proposed, the result might have been different. One of the principal objects of this paper has been to ascertain if, as has been stated, fecal fistula is an invariable consequence of laparotomy for abdominal inflammation in cases where pus has already escaped by the rectum?

## DISCUSSION.

*Dr. J. Scott*, of San Francisco. I would mention the following case: A patient was admitted to the hospital with prolapse, inflammation of the ovaries and cellulitis. After three months' treatment without improvement, removal of the ovaries was recommended but declined by the patient. The patient was kept under treatment for six months longer when enlargement of the right ovary began. Later pus discharged by the rectum and subsequently the abscess opened into the bladder. The patient then consented to operation. The abdomen was opened, an opening made into the vagina and a drainage tube introduced. The improvement was not marked and in the course of two months the patient was as bad as ever. The removal of both ovaries and tubes was then performed. Four or five days after the operation feces appeared in the wound. During the five months suc-

ceeding the operation the fecal fistula has closed, the patient has gained ten pounds and is able to walk about.

*Dr. William Goodell*, of Philadelphia. The only case which I have had at all similar to the one reported, was one of pelvic abscess opening into the rectum and bladder. I performed laparotomy with the intention of opening the abscess and stitching its walls to the abdominal wound. The abscess has been so constantly drained that it was not larger than a pear. By compressing the abscess sac, I was able to make it prominent in the vagina and forced into it a closed pair of scissors, which were then opened and the opening gradually enlarged and a drainage tube inserted. This case gradually recovered, both the rectal and vesical openings closing in the course of time.

*Dr. C. C. Lee*, of New York. I think that the rule will come to be established that in chronic suppurative peritonitis, laparotomy is not only justified but the procedure to be adopted.

*Dr. R. S. Sutton*, of Pittsburg. In a case of pelvic abscess as large as a coconut, I performed laparotomy and then stitched the peritoneum at the edge of the incision to the peritoneum covering the abscess, which was then opened and a drainage tube introduced. The patient recovered.

*Dr. Joseph T. Johnson*, of Washington. I would suggest that in such cases as the one described by the author where time is a matter of importance, much can be gained by adopting the procedure employed by Dr. Bantock and Tait. In washing out the abdominal cavity they pour water into the cavity with a pitcher using gallons at a time. In this way the cleansing is rapidly accomplished.

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TREATMENT OF PRURITUS.—A solution of menthol, two to ten grains in the ounce, is said to be a very effectual remedy in the treatment of the troublesome itching which accompanies urticarial eczema, and pruritus.—*British Medical Journal*, August 28, 1886.

## MARYLAND MEDICAL JOURNAL

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BALTIMORE, OCTOBER 2, 1886.

**Editorial.**

THE MATERIES MORBI OF MALARIAL FEVER.—Considering the evidence now at our command upon the infectious nature of malarial fever, we are almost persuaded that we have at last reached the materies morbi of this disease, in the plasmodium malariae, which Marchiafava and Celli describe as being present in the blood of all persons sick of this malady.

Numerous other pathogenic organisms have been described by various observers as the cause of malarial fever, and among the first may be mentioned an organism described by Salisbury, who claimed to have found in the blood of patients affected with malarial fever a body belonging to the unicellular algæ. He claimed to have produced the fever by having persons sleep in a room in which there was fresh earth containing this organism. At present there are few who credit these statements of Salisbury, and in consequence they have sunk into oblivion and have naught but an historical value to recommend them. Lanzi investigated the vegetable life of the Campana and Pontine marshes, and describes, as a reward for his work, what he considers a form of sphero-bacteria. He thinks this organism possesses characteristic fermentive properties, and, when having gained access to the human system, has, by virtue of this ferment, the power of producing malarial fever. This organism is of a black color, and he attributes the pigmentation of the tissues and the

melanæmia to its heaping up in the capillaries.

Afanassieur believes the black pigment to result from the heaping up of a chromogenic bacterium, which he thinks is the etiological factor in producing the disease.

Up to the time of its production, probably the publication to which the most importance was attached, was that of Klebs and Tomassi-Crudeli, who described as the agent in the production of this disease a bacillus that they found in the earth of marshy districts, and which they claimed to have cultivated, and by inoculation with it, to have produced the disease in rabbits. These experiments were carefully repeated in every detail by Sternberg, with, in each instance, only negative results, nor has any other competent mycologist met with aught but failure in his efforts to confirm their statements.

Laveran, a French Army Surgeon, investigated the disease in Algeria, and described (*Nature Parasitaire des Accidents de l'Impaludisme, &c.* Paris, 1882) as a result of his labors, organisms which he finds in the blood of malarial patients, and which he takes to be the causative elements in the production of the disease. When seen under an amplification of 400 or 500 diameters, he describes these bodies as being of three varieties.

Bodies No. 1, he says are elongated, and often curved like a crescent, though sometimes they are oval. Their length is 8 to 9 *M.*, and their width 3 *M.* Their contour is very delicate and colorless, except where pigment granules are contained in them.

Body No. 2.—This body presents a different aspect according as it is in motion or at rest. In a state of repose it appears as a body somewhat larger than a red blood-corpuscle, having in its interior black pigment regularly arranged in a circlet. When in motion there are seen attached to the organism delicate filaments which are in active movement.

Body No. 3.—While primarily spherical in form, is seen to pass through stages in which great variations in outline are observed.



Besides the bodies described, he saw in the blood small, brilliant, round mobile bodies without specific characteristics, and, also, grains of pigment of a fiery red and of a pale blue color. In four cases examined after death, the brain, spleen and liver presented the characteristic appearance and microscopic examination revealed the presence, in each instance, of these bodies in the capillaries. He thinks these bodies belong to the oscillatoriæ, and has given them the name of "oscillatoriæ malarie."

Kelsch calls attention to the presence of pigmented bodies in the blood of malarial fever patients, and considers their presence diagnostic of the disease.

Richard describes an organism in the blood of patients suffering from malarial fever. His description of the body, though differing from that given by Laveran for the bodies observed by him, still may be considered as confirmatory of Laveran's observations, for it is probable that the bodies seen by Richard were identical with those of Laveran, the difference in description resulting from their being in one of the many transitional stages at the time of observation.

Councilman and Abbott, in the *American Journal of the Medical Sciences*, April, 1885, gave the result of post mortem examinations on two fatal cases of the comatose form of malarial fever. They described, as a result of these autopsies, the characteristic chocolate color of the brain, the bronzed liver, the enlarged and blackened spleen, and, in short, the appearances of the viscera so common to this disease.

Upon microscopic examination of sections of these tissues they detected in the red blood corpuscles and free in the capillaries, small, round, hyaline bodies whose nature they were at a loss to interpret. They were examined under a  $\frac{1}{6}$  oil immersion lense, and an Abbe substage condenser, and their behavior with the different reagents accurately noted. While in many respects these bodies answered to the description given by Laveran, yet it was difficult to reconcile the appearances made out by them, not without difficulty, under so high an amplification, with those given by Laveran,

and which were apparently easy of demonstration under so comparatively low magnifying power as 400 or 500 diameters. Their examinations of fresh blood, made at that time, from other patients suffering from malarial fever, gave only negative results. In concluding their paper, the authors remark—"We present here the facts only as we have found them; we confess our inability to say what these hyaline bodies are. That they have been seen before by other observers appears most likely."

Apparently without their being aware of it, this paper of Councilman and Abbott was antedated by about five months by the first of a series of publications by Marchiafava and Celli, who have given the results of a large number of autopsies on patients dead of this disease and many examinations of blood during life. They describe in the blood of all malarial cases, especially those in which the typical fever is present, a small body which readily stains with the aniline dyes and which has for its habitat the body of the red blood-corpuscle, though they are also found free in the blood. It is described as appearing as a round, spindle shaped, oval or irregular structure which may or may not contain black pigment granules. When examined in a fresh state in the blood these bodies are seen to possess an amœboid movement, which movement is lost in all artificial media in which they may be manipulated. The forms of this body in which the filaments are present and which appear to be identical with body No. 2 of Laveran, seem to occur less frequently than the structures that are devoid of these flagellæ, as they were only observed in four out of forty-two examinations. The round pigmented variety is usually present in greatest numbers. When occurring in the form of pigmented crescents the authors consider it an indication of a more intense degree of infection, this being the stage of the organism most common in the pernicious form of the fever.

They consider the many forms of this body as developmental phases of one and the same parasite—the specific parasitic element of malarial fever. It is

not looked upon by them as one of the bacterial forms, but as a representative of the class of protozoa, and they give to it the name of "Plasmodium Malariae." Their efforts to cultivate this organism in artificial media have given throughout negative results, though their inoculations of blood of malarial patients into healthy human beings resulted in producing a typical intermittent fever in three out five inoculations, the remaining two they state, though not negative, were not sufficiently positive to warrant their claiming them as successful. Notwithstanding their failure to cultivate this organism, they consider themselves justified in regarding it as the etiological factor in malarial fever.

In reviewing the above contributions to the subject of the etiology of this malady, it will hardly be denied that, if its parasitic nature be admitted, the weight of evidence is in favor of the bodies described by Marchiafava and Celli.

It illustrates most clearly the value of the caution laid down by Koch: that in investigating diseases for their cause, we should not confine our search to bacterial forms alone, but should be prepared to encounter other varieties of vegetable and animal life that possess fermentative properties which may, when introduced into the human system, have the power of producing disease.

It must not be considered, however, that we accept these publications without reserve as conclusive proof of the etiological value of these bodies, for with such a limited knowledge of the life history of the organism, such a step would be unjustifiable in the extreme. Up to the present, all efforts to study this organism in any other medium than that in which it is found have failed, but at the same time, there are constantly being put forth efforts to discover some substance or method by which it may be artificially grown, and until such efforts are successful, the value of this body in the rôle claimed for it must necessarily be held *sub judice*.

The Ovaries: The Lord gave and the man taketh away. Happy is the man who hath his jar full of them.—*Med. Record*.

## Book Reviews.

*Diseases of the Prostate.* By SIR HENRY THOMPSON. Sixth edition. Philadelphia, P. Blakiston, Son & Co. 1886.

No commendation is needed for a book that holds such an assured place in medical literature as Sir Henry Thompson's work on the prostate. It is now nearly thirty years since the book first appeared, and it must be highly gratifying to the author to respond to the call for a new edition. At this time, this flood tide of medical publications, when every specialist feels in duty bound to 'spawn' at least one book a year upon the profession, it is a good monograph that lives even ten years, and the sixth edition of Sir Henry Thompson's book begins its thirtieth.

In the first few chapters, devoted to the anatomy of the prostate, there has been little change from the original text; the second part, treating of the diseases of the gland has been rewritten to a considerable degree. The most prominent affection of the prostate is of course the enlargement which occurs in advancing life, and this subject occupies a large part of the book before us.

The remarks on the treatment of this latter affection, while clear and decided, seem to us hardly up to date either therapeutically or surgically. The remaining chapters are devoted to less frequent diseases of the glands, calculus, malignant affections, atrophy, tubercle, etc.

The general practitioner is still longing, however, for some radical means which will relieve his old patient, comfortably, of his urine, and himself of the dread of catheter fever.

*The Healing of Arteries after Ligation in Man and Animals.* By J. COLLINS WARREN, M.D., Assistant Professor of Surgery, Harvard University, Surgeon to the Mass. General Hospital, etc., etc. New York, Wm. Wood & Co.

The book opens with a rather long, but quite interesting history of the ligation of arteries from the time of the an-



cient Alexandrian down to that of the modern German School. Then follows a carefully prepared list of experiments on animals, large and small.

The observations on the ligature of special arteries in man, with descriptions of specimens, are very interesting.

The closure of the foetal vessels is discussed at some length, and the author closes his monograph with a very good summary. He shows clearly, how the long end of the ligature left in the wound interferes with primary union, and the obvious advantage in cutting close to the knot, holding that silk or hempen ligatures rendered antiseptic are either encysted or absorbed.

Many of the plates in the book are very handsome, and the press work is of an unusually high order.

*Electrolysis: Its Theoretical Consideration, and Its Therapeutical and Surgical Applications.* By ROBERT AMORY, A.M., M.D., Fellow of the American Academy of Arts and Sciences, Fellow of the American Academy of Medicine, &c., &c. (Wood's Library.) New York: Wm. Wood & Co.

The first third of the book is devoted to a highly scientific discussion of the Physics of Electrolysis, with a description of the various batteries and their accessions.

The author explains, so far as any explanation is possible, the curious change that the low tension current produces in the vital tissues. This change must be very similar, if indeed not identical, with that brought about in the familiar experiment of resolving water into its original elements by the electrical current. Generally speaking, the application of electrolysis is confined to hypertrophies and exudations, though doubtless after more extended experimentation of its sphere of action will be largely increased.

Much may be expected from electrolysis in the treatment of aneurism, for many failures have certainly occurred from using currents of too great intensity, or, as in some reported cases, the

interrupted current which is now clearly shown to be the worst possible form to apply. Ciniselli's late cases are certainly encouraging.

Good results have been obtained by this mode of treatment in angioma, ovarian and other cysts, and several varieties of tumors, and in simple and exophthalmic goitre, though in this latter affection, the author claims a much higher place for electrolysis as a means of cure than we are willing to grant. In hypertrichosis or excessive growth of hair, this method by treatment has gained an assured and permanent place, although the application of it is very tedious.

Some very interesting operations have been performed on the foetus in extra-uterine pregnancy, both with the surface current and the puncture, in either case resulting in its speedy and permanent reduction into an harmless cyst.

It may be that the author's zeal has caused him here and there to lay in the rose color, but certainly no one can read his book without being convinced that electrolysis has a bright future before it.

Reed & Carnrick, of New York, have issued a little book suitable to carry in the pocket, containing very suggestive diet tables in various diseases. The tables have evidently been prepared with care, and may prove useful to the physician who attends to that very important part of treatment.

### Miscellany.

THE DIURETIC ACTION OF WATERMELON.—In the course of a prolonged study of remedies used in Russia as diuretics, Popoff (*Vratch*, No. 4, 1886) finds that watermelon has been commended as an extremely cheap but effective substitute for grapes in the treatment of chronic congestion of the liver, chronic intestinal catarrh, etc. It is extensively used by the peasantry in Southern Russia (especially near the river Don, and in the Caucasian districts) in the form of the freshly expressed

juice, as a diuretic draught in cases of dropsy, urogenital affections (especially gonorrhœa), etc. The author experimented with the inspissated fresh juice or syrup of the fruit, and with commercial melon-honey (*arbooznyi modid*): The diuretic action proved most striking; when animals received from 50 to 100 grammes of the syrup (with food) in twenty-four hours, the daily quantity of urine was three or four times greater than under ordinary conditions; again, on intravenous injection of the syrup "the urine for several minutes flowed in a stream from a canula tied into the ureter." On the subcutaneous injection of 0.4 to 0.7 gramme into frogs the syrup rapidly slows the cardiac action up to complete arrest in diastole, and produces prostration with loss of voluntary movements, while reflex action and the excitability of the motor nerves and muscles remain intact. When very large doses are used, in the latest stages there is observed, also, a failure of reflexes and of nervo-muscular excitability, but the phenomenon is then undoubtedly nothing but an ordinary symptom of præmortal agony. In dogs the internal administration of 500 grammes at a time produces no effect except powerful diuresis. Intravenous injection of one to two grammes of the syrup causes an immediate increase in the secretion of the urine, the latter assuming a dark color and containing sugar. This increase lasts for ten to sixty minutes, and is accompanied only by a slight fleeting decrease in the blood-pressure. On the injection of 0.25 to 0.5 gramme for each kilogramme, a considerable fall of the pressure and a great acceleration of the pulse rapidly follow. An intravenous injection of 3 grammes per kilogramme produces a further fall of pressure and a fleeting increase, with a subsequent sudden enormous decrease in the frequency of the pulse, the animal dying from cardiac paralysis. Experiments show that the quickening of the cardiac action is dependent upon the syrup acting on the peripheral ends of the vagi. In all cases intravenous introduction of the syrup rapidly produced a strong sedative effect, "the animal remaining strikingly quiet,

and giving no response to tactile or even pathic irritation." Another group of experiments showed that the diurectic action of melon-syrup was dependent mainly upon its direct influence on the renal tissue.—*London Medical Record*, June 15, 1886.

**SALICYLATE OF COCAINE IN ASTHMA.**—A comparatively new method of treatment in asthma nervosum has lately been tried by Professor Mosler, of Greifswald. It is now well known that cocaine has not only a local action on the sensory nerve-endings, but also a central one, which, at first stimulating to the nerve-centres, may, if the drug be pushed, become sedative or even narcotic. By this peripheral or central effect, it may, therefore, act in such spasmodic diseases as asthma. Early last year, Beschorner published two cases of this disease which were much benefitted by cocaine. In three cases, Professor Mosler has obtained excellent results. All these cases occurred in young people of 23 to 25 years of age, and were uncomplicated by any organic heart or lung disease. The drug was given subcutaneously, in doses of 0.4 gramme (6 grs.; this seems an exceptionally large and dangerous dose), at the commencement of the attack. The first patient, who had a bad family history as regards lung-disease, and in whom the asthma had lasted eleven years, was relieved after the third injection; two more doses caused abeyance of the attacks (which occurred previously every day) for a fortnight, when the patient was lost sight of. In the second and third cases, the treatment was more rapid in cutting short the attacks, which in the end were postponed for two or three weeks, during which the patients continued under observation. The injections caused, in one case, a slight sense of faintness and the appearance of dark spots before the eyes; but these symptoms soon vanished. It is, of course, impossible to draw from these cases any conclusion as to the permanent benefit of the treatment. Extended experience will perhaps show that the drug is only a palliative. It is the hope of inducing other practitioners to try



the treatment that Professor Mosler has published the results of his cases.—*British. Med. Journ.*, July 17, 1886.

ANTIPIRYN AS AN ANALGESIC IN HEADACHE.—DR. JOHN BLAKE WHITE, Physician to Charity Hospital, New York, sends to the *Medical Record* the following:

"The high road to truth is the knowledge of facts, and well is it for searchers after truth when facts can be ascertained and carefully recorded.

"Symptoms are the alphabet, cases the language, of disease, and that physician subserves his profession who carefully records his experience.

"During the past two years I have abundantly tested the therapeutic value of the drug known as antipyrin in various forms of headache. The prompt relief obtained through its use compels me to accord to it a high rank among our medical resources. I have already called attention (*Medical News*, July 10, 1886) to the potent antipyretic power possessed by this remedy in the management of various forms of fever, and have observed that after its administration the urgent symptoms of headache, so uniformly present in these cases, was soon controlled.

"Antipyrin undoubtedly possesses bradycrotic properties in a high degree, as the pulse is notably softened and moderated in frequency soon after a proper dose of it has been taken. It produces some somatic change favorable to a reduction of the pulse in cases of fever, and so exerts a calming influence upon the vaso-motor system. The capillaries, through its agency, doubtless dilate, and local congestions are dissipated, as the relieved patient usually sinks into a refreshing repose soon after its exhibition. In the course of large experience with antipyrin I have found that, when administered in masterful doses, it not only promptly relieves the symptoms of headache whenever present, wheather resulting from disordered digestion, disturbance of the menstrual functions, loss of sleep, undue mental effort, or even that associated with dreaded uræmia, but also possesses reliable

prophylactic virtues against recurrent attacks of cranial neuralgia. So confident am I of the power of this remedy to disappoint neuralgic headache when imminent, that I have instructed many patients, who are liable to such visitations, to keep in readiness and take a dose of antipyrin as soon as they have premonition of its recurrence, and all so far testify in favor of its efficacy.

"The value of this remedy in the above respects has not only been tested in my hospital and private practice, but I also record the fact that it has proved successful in the hands of professional friends, upon whom I had urged its employment for the relief of neuralgic affections of the head and face. I have been singularly impressed with the promptness of relief which often followed the administration of even a single dose of fifteen grains of the antipyrin. The grateful relief from headache usually ensues within half hour after the drug is taken. A sense of drowsiness ordinarily supervenes, followed by a brief but sufficient slumber, and the patients awaken quite relieved of this distressing symptoms. I have never yet seen the sleep-disposing properties of antipyrin alluded to by any other observer, although this effect seldom fails to ensue when a full dose such as I have named has been taken."

ANOTHER NEW ANTIPIRETIC-ANTI-FEBRIN.—It would seem as though there were already a sufficient number of antifebrile remedies to satisfy the most enthusiastic therapist, but the list is being added to almost daily, and the clinical mine shows as yet no signs of threatened exhaustion.

The latest discovery in this direction is announced by Drs. Cahn and Hepp, of Strassburg, in the *Centralblatt für klinische Medicin* of August 14, 1886. The substance is known chemically as an acetanilid or phenylacetamid, the formula for which is  $C_6H_5NHC_2H_3O_2$ , but the writers have given it the more convenient name of antifebrin. It is a clean, white crystalline, odorless powder, imparting a slight burning taste when placed on the tongue. It is almost insoluble in cold water, dissolves with

difficulty in hot water, but freely in alcoholic liquids, such as wine. It melts at 235.5° F., and sublimes unchanged at 557.5 F.° It possesses neither acid nor basic properties, and is very rebellious to the action of most reagents.

The authors have experimented with the remedy in a number of febrile troubles—among others typhoid fever, erysipelas, acute articular rheumatism, pulmonary phthisis, and septicæmia—and state that the results obtained were very satisfactory. It is given in doses of from four to fifteen grains, shaken up in water, dissolved in wine, or enclosed in wafers. A maximum dose of thirty grains per diem was not exceeded. In general terms it may be stated that it is of about four times the strength of antipyrin.

The effect of the drug upon the temperature is noticed at the end of about an hour, and attains its maximum usually in about four hours, passing off again, according to the size of the dose, in from three to ten hours. The action of antifebrin manifests itself externally by a reddening of the surface and moderate perspiration. The patients sometimes complain of a cold feeling, though there was never any decided chill noticed.

The pulse-rate falls proportionately to the temperature. There was never any nausea caused by even large doses.

In conclusion, Drs. Cahn and Hepp speak enthusiastically of the marked antipyretic properties of the new drug, and of the absence of any untoward symptoms attributable to it. It has also, they claim, the advantage of cheapness, being obtainable for the moderate price of about twenty-five cents an ounce at wholesale.—*Med Record*.

**CARBOLIC ACID IN THE TREATMENT OF WHOOPING-COUGH.**—Dr. C. W. Suckling writes to the *Brit. Med. Journ.*, (July 24, 1886) that he has used the glycerin of carbolic acid with great success among his out-patients at the Children's Hospital in the treatment of whooping-cough. He had previously used almost every other drug in different cases, but never with any satisfactory results. He states that he has notes of twenty-three cases treated with glycerin of carbolic acid.

Half a minim in peppermint-water is sufficient for a child a year old, the dose increasing with the age. In twenty cases, relief was quickly given; the general condition of the patients was at once improved, and the number and severity of the paroxysm of coughing diminished. None of the cases attended more than a fortnight, while the usual length of attendance is certainly twice as long. In three cases, the carbolic acid failed to give relief. There was no doubt as to the nature of the illness in these cases, for in all the characteristic cough was heard, or ulceration of the frænum present.

Dr. Suckling has observed ulceration of the frænum to be present in fifty per cent. of cases of whooping-cough, and he believes that its presence is pathognomonic of the disease. He also believes carbolic acid almost deserves to be called specific for pertussis.

**REMOVAL OF MOLES AND WARTS BY ELECTROLYSIS.**—Voltolini† uses a battery of five elements. Two kinds of needles can be used, one of platinum, the other of steel. The latter needle is intended for very hard warts, and must be attached to the negative pole to avoid oxidation. Moles and warts must be soaked in water. The needles must never be introduced deeper than the level of the skin, nor be allowed to touch one another. The action of the galvanic current may be continued from five to ten minutes at most, the needle being pushed in different directions, whilst water is allowed to drop on to the part operated on. In from two to four minutes, the substance of moderately soft warts becomes pulpy. This is the indication for the operation to stop. This pulp dries up, becomes black, and in a week or fortnight falls off.—*Boston Med and Surg Jour*.

**INSTRUCTION IN PATHOLOGY AT THE JOHNS HOPKINS HOSPITAL.**—Programme for 1886-7. The Trustees of the Johns Hopkins Hospital have allowed the use of the Pathological building, on the Hospital grounds, for the prose-

†Deutsche Med. Wochen., No. 7, 1886.



cution of pathological studies. It has ample accommodations and will be thoroughly equipped at the beginning of the next academic year.

Systematic instruction in Pathology will be given in this Laboratory during the academic year 1886-87. No one will be admitted to the courses in Pathology who has not a fair knowledge of the normal anatomy, histology, and physiology of man. The following courses of instruction will be given:

1. Pathological Histology by Professor Welch and Dr. Councilman.

*This course begins November 1, 1886, and continues three days weekly for four months.*

The course includes the preparation and study of diseased tissues and organs. Attention will be given to the subjects both of General and of Special Pathology. The laboratory is furnished with a rich collection of pathological specimens for purposes of microscopical study.

2. Demonstrations in Pathological Anatomy by Dr. Councilman. This course begins November 1, 1886, and consists in weekly demonstrations of fresh pathological specimens.

3. Method of making Post-mortem Examinations by Dr. Councilman. Instruction in this subject will be given at the Bay View Hospital.

4. Bacteriology by Professor Welch. *Daily during March and April, 1887.* The methods of isolating and of cultivating micro-organisms and the morphological and the biological properties of the most important species, particularly of the pathogenic forms, will be taught. The laboratory is supplied with a complete set of apparatus for bacteriological work.

5. Lectures on the General Pathology of Fever by Professor Welch. *Once a week during February, March, and April, 1887, in Hopkins Hall.* The Pathological Laboratory is ready for the reception of physicians or of advanced students who, after suitable preliminary training, wish to undertake special research in any branch of General or of Special pathology, including Experimental Pathology and Bacteriology.

A Fellowship in Pathology yielding five hundred dollars in addition to free tuition will be granted in October 1886, if a suitable candidate applies.

The application must be made prior to October 1. The candidate must give evidence of a liberal education (including especially physics, chemistry, biology, and modern languages) and of special aptitude for pathological study, such as that afforded by some previous scientific work. The holder of the fellowship will be expected to devote his time to some special line of investigation (not strictly professional) under the direction of the Professor of Pathology. Further information concerning the purposes and the regulations of University fellowships is contained in the Annual Register.—*University Circular.*

OPERATIVE TREATMENT OF FRACTURE OF THE PATELLA.—The operative methods now in vogue are:

(1.) Evacuation of articulative effusion by aspiration or puncture.

(2.) Tendon ligature, (Volkmann).

(3.) Bone suture. Introduced by Lister in 1877, either open or subcutaneous, the most recent plan of which is that of Ceci.\*

(4.) Malgaigne's Hooks.

(5.) Morton's Method.

Dr. Conrad Brunner,† of Zurich, has recently published an exhaustive and carefully-written article intended to show the comparative treatment of fractures of the patella. The data from which he has formed his conclusions consist of detailed histories of forty-four cases treated by the former method and statistical tables containing the essential points in ninety cases of fracture treated by suture.

The operative method being a comparatively modern procedure the final results cannot be so fully learned as those of the older plan. However, the results, as far as can be obtained, show that the opening of a knee-joint to suture a pa-

\*Eine neue Operation der Patellar Fracture. Subcutane Meßschnitte der Kneeschebe. Deutsche Zeitschrift f. Chirurg. Bd. xxiii, Heft. 3-4.

†Ueber Behandlung und Endresultate der Querbrüche der Patella. Deutsche Zeitschrift für Chirurg. Bd. xxiii, Heft, 1-2.

tella is entirely unjustifiable in the great majority of cases. Brunner finds that the simple method gives practically as good results and hence concludes that there is no real necessity for the operation, for the primary object of treatment is in his opinion to restore the function of the limb and not to secure bony union. And in regard to this point the operative method cannot show any better results than those obtained after the older method. Since among the cases operated upon records exist of eight cases of suppuration, two requiring subsequent amputation of the thigh, nine resulting in ankylosis, and three deaths. It can scarcely be regarded as a method of treatment unattended by danger, and the danger thus incurred by the patient is not compensated for by a better functional result than can be obtained by a simpler method devoid of risk.

Chauvel† has reported forty-three cases with severe arthritis in twenty; 120 amputations and three deaths.

According to the final results now on record it seems to be unwarrantable to transform a simple fracture into a compound one, to secure bony union which does not give the patient a better functional result than is obtained in a case of ligamentous uniting of the fragments. The claim that the duration of treatment is shortened is not supported by statistics.

The conclusions to be drawn from the above are that all cases of this injury should be treated by the "simple" method, except when a free communication with the fracture already exists or where a badly united fracture or useless limb demands a more effectual treatment.—*Boston Medical and Surgical Journal*.

**BISMUTH SUBNITRATE IN FŒTID PERSPIRATION OF THE FEET.**—Vieusse (quoted in *Practitioner*, May, 1886) draws the following conclusions: 1. Profuse perspiration of the feet, whether accompanied by pain or fœtidity, is easily cured

by the application, with slight friction, of subnitrate of bismuth upon the diseased parts. 2. In opposition to the opinion generally held, according to which the suppression of exaggerated perspiration may produce numerous accidents of metastasis, observation shows that the cure of this affection has not been followed by any unfavorable results, and that, if these are observed, they should be attributed to other methods of treatment hitherto employed. 3. In the cure of this disease, subnitrate of bismuth appears to exercise a purely local action, rendering the superficial cuticular structures firmer and more resistant. 4. In certain cases the remedy suppresses only temporarily the profuse perspiration of the feet, but causes the fœtid odor, as well as the pain, which is the consequence of the exaggerated secretion, to disappear permanently.—*N. Y. Med. Jour.*

**OIL OF EUCALYPTUS IN MALARIAL DISEASE.**Dr. J. H. Musser (*Ther. Gaz.*, June, 1886) gives a critical analysis of the results he had obtained with eucalyptus in the various forms of malarial poisoning. Great care was exercised in diagnosis, and twenty-eight patients were selected for treatment. Of these, nine were cured, ten not cured, five were relieved, but other drugs were used in addition, and five did not report a second time. Analyzing nine cured cases, one was of quotidian type, five were tertian, one was quartan, and two were irregular. The disease was acute in five, chronic in four. The cases were under observation from ten days to six months. All the attacks developed in the usual malarial season, and seven of the patients resided in a positively well-known malarious locality. The drug was administered in forty-four other cases in which the symptoms showed a periodicity and consisted in irregular febrile invasions, gastro-intestinal disorder, and neuralgias. Only eighteen of these cases remained under observation long enough to be of any statistical value. Fourteen patients were relieved and four not relieved.

†De la suture osseuse dans les cas de fracture transversale de la rotule avec écartement. Centralblatt für Chirurgie, 1884, S. 377, Referat.



The former were under observation from five days to a year.

The oil, which is quite distasteful, may be administered in capsules, in emulsion, or in glycerin. Most of the author's patients took it on a lump of sugar. Ten drops are usually given to adults, three or four times daily. The author thinks smaller doses (gtt. iij-v), repeated oftener, would prove more beneficial.

He draws the following conclusions; 1. Oil of eucalyptus is of decided value in about one third of all cases of intermittent malarial fever. 2. It has no specific value in any one type of the disease. 3. The longer the duration of the disease, the less liable is it to do good. 4. Relapses are not prevented by it. 5. Its influence on the spleen has not been demonstrated. 6. A dose of ten drops four times daily is a sufficient dose, but five drops every three hours would possibly be of greater value. 7. Good results are not attained so quickly as by large doses of quinine, but a good effect should be observed within five days at least.—*N. Y. Med. Jour.*

**A CONTRAINDICATION OF PARALDEHYDE.**—It has been asserted that paraldehyde does not give rise to any unfavorable secondary symptoms, and that there is no known contraindication to its administration, remarks the *Therapeutic Gazette*. It quotes, however, from the *Neurologisches Centralblatt*, No. 11, 1886, a little note by Dr. Sommer, of Allenberg, which renders the correctness of these views doubtful. A patient, 18 years of age, who, for six successive days, had taken daily doses of one drachm of paraldehyde, showed on the seventh day, a few minutes after having drunk half a bottle of beer, a deep scarlet injection of the skin, covering almost the entire head, neck, back, posterior surfaces of the lower extremities, and partially the chest, abdomen, and upper extremities. This peculiar phenomenon lasted half an hour. For the sake of an experiment, Sommer gave the patient on the next evening another dose of paraldehyde, followed by a small quantity of alcohol on the next morning. The same vascular injection having ap-

peared again, Sommer concluded that paraldehyde ought not to be given to patients presenting atheromatous defects, and should, at least, not be employed in connection with alcoholic liquids. Only one other observer, Eickholdt, has previously observed similar interferences of the circulation following after the employment of paraldehyde. He noted the occurrence of cerebral congestions and of vaso-paralytic symptoms after the prolonged use of this drug.—*Boston Med. and Sur. Journal.*

**HIPPURATE OF CALCIUM IN THE TREATMENT OF CIRRHOSIS OF THE LIVER.**—M. Du-jardin-Beaumetz (*Union Méd.*, August 19, 1886) employs the following preparation:

Hippuric acid	6 drachms;
Lime-water	16½ ounces;
Syrup	20 “
Essence of lemon	1 drachm.

Dose, a tablespoonful several times daily, so that the equivalent of from one to two drachms of hippurate of calcium may be given. Under the use of this drug the writer has observed a marked amelioration of the ascites attending cirrhosis.—*N. Y. Med. Jour.*

**AN ANTI-DYSPEPTIC MIXTURE.**—Marini (*Union Méd.*, August 19th) is credited with the following:

Tincture of nux vomica,	} each 2½ drams.
Tincture of cinnamon,	
Tincture of anise,	
Tartrate of iron,	

Dose, thirty drops before each meal in a wineglassful of water. Between the two principal meals a teaspoonful of powdered charcoal should be given.—*N. Y. Med. Jour.*

**A PILL FOR DYSURIA.**—Mallex, (*Union Méd.*, August 14th) suggests this formula:

Venice turpentine	1½ drachms;
Camphor	1 “
Extract of opium,	5 grains.
Extract of aconite,	5 “

Divide into sixty pills, from three to six of which may be administered daily.

Glycerin	1 ounce.
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*N. Y. Med. Jour.*

**THE CURE OF TUBERCULOSIS.**—A subscription for the purpose of encouraging researches in the therapeutics of tuberculosis has been opened by the *Gazette Hebdomadaire de Médecine et de Chirurgie*, of Paris. The idea of a subscription for this purpose was suggested by M. Verneuil, and in a few days the sum of over four thousand francs was raised.—*Med. Record*.

### Medical Items.

The American Academy of Medicine will hold its next regular annual session in Pittsburgh, Pa., October 12th and 13th.

Free dispensaries are said to be almost unknown in France, there being only three in Paris. What a paradise for young doctors such a country must be!

Reports of mistakes upon the part of druggists, in substituting morphia for quinia, appear unusually frequent in our medical exchanges. The latest announcement of this fatal accident is from Columbus, Ohio. There should be some rule adopted by druggists to prevent this occurrence. The similarity in the appearance of the two drugs is responsible for the error.

Dr. R. T. Edes, a prominent physician of Boston, has resigned a Harvard professorship and a large practice in Boston to remove to Washington City, where he will in future practice his profession. No reason is assigned for this move, but it is believed that Dr. Edes sees in the National Capital more brilliant prospects for social and professional advancement than now exist at Harvard or in the "Hub."

Leopold von Ranke, now more than ninety years of age, presents the anomaly of a man who has never taken any physical exercise and is yet in perfect health. The German historian has almost lived in his library, working for fifteen hours a day, and he has laid out more work which he hopes to complete before his hundredth birthday.—*Medical Times*.

The *Medical Record* says: "A Russian peasant woman, who desired to pass off an infant as her own, in order to make it appear that she had just been delivered, procured the lung of a sheep to answer as a placenta and seminal duct of a he-goat to represent the umbilical cord. The deception was discovered by Dr. Solovjeff, who relates the case in the *Volkhski Vestnik*."

On Monday October 4th the Medical Schools, of this city, will begin their regular courses of lectures for the session of 1886-87. At the University of Maryland Professor R. Dorsey Coale will deliver the opening lecture, at 10 A. M. Professor O. J. Coskery will deliver the inaugural address at the College of Physi-

cians and Surgeons. At the Woman's Medical College the opening lecture was delivered on Friday, October 1st, by Professor Russell Murdoch.

The following is related by several of our exchanges of a young physician, who had just established himself, and had very little practice, but who was noted for his braggadocio. One of the older physicians, meeting him on the street yesterday, asked him how he was coming on. "I've got more than I can attend to," was the boastful reply. "I had to get out of my bed five times last night." "Why don't you buy some insect powder?" asked the old doctor.

A death is reported in France from the application of collodion to the face of a woman suffering from small-pox. The design of the application was to prevent pitting. Suppuration took place under the mask of collodion, and the patient died after great suffering. As the small-pox was discrete and uncomplicated and the autopsy showed no visceral lesions, the fatal termination would seem to have been due to the injury resulting from the collodion.

Dr. Thomas Legaré, of Charleston, S.C., writes to the *Medical Record* requesting that the statement that the physicians of Charleston are in great need be contradicted. Dr. Legaré says: "The profession in Charleston has just held a meeting, in which it was found that while some few may solicit and accept aid as private individuals, the medical profession of the city as represented by its leading members would under no circumstances accept money assistance, nor do they desire to be placarded as mendicants."

Dr. Christopher Johnston, who has been travelling in Europe for some months, will, we learn, reach his home in this city, about October 1st. During his absence abroad Dr. Johnston has visited the extreme Northern portion of Europe in the region of North Cape. From this land of midnight sun the doctor has written several interesting and graphic descriptions of his observations and experiences, which have appeared in the *Baltimore American*. Dr. Johnston's friends will be glad to welcome him back to his home reinvigorated in body and spirit.

On Wednesday evening of the present week the medical profession of Philadelphia tendered a reception to Dr. E. O. Shakespeare, at the Hotel Bellevue, in recognition of his services during his recent visit to Lower Europe and India. Dr. Shakespeare was sent out under the auspices of the U. S. Government for the purpose of investigating the causes and means of dissemination of cholera. After an absence of some months, he returns with data which will shortly be presented in the form of a report to the Government. The reception given by his professional brethren in Philadelphia is an evidence of the high esteem in which Dr. Shakespeare is held in his own city.



Selected Articles.

SCARLATINA AND SCARLATINIFORM ERUPTIONS FOLLOWING INJURIES AND OPERATIONS.\*†

BY I. E. ATKINSON, M.D.,

Professor of Materia Medica and Therapeutics and Clinical Medicine, and Clinical Professor of Dermatology in the University of Maryland.

Although reports of scarlatina and scarlatinoid eruptions following injuries and surgical operations were to be found in medical literature, general attention was more especially attracted to them by Sir James Paget in 1864 in a clinical lecture. In his "Clinical Lectures and Essays" (1875) he devotes a chapter to the subject. He says: "There is something in the consequences of surgical operations which makes the patients peculiarly susceptible to the influence of the scarlet fever poison." In France, Trélat‡ was the first to accept the views of Paget concerning the nature of these rashes, though they had already been observed by Civiale, Germain Sée, Tremblay, and others. Rashes more or less resembling scarlatina were reported by Jonathan Hutchinson, Hilton, Bryant, Lea, Moore, and others, and in St. George's Hospital Reports for 1879 is a notable article by Stirling, in which the subject is continued. Scarlatinoid rashes in surgical cases had generally been considered to be of septicæmic origin. In Guy's Hospital Reports for 1879 appeared two papers supporting the proposition that an especial liability to scarlatina is shown by those who have recently sustained injuries or undergone surgical operations. The first of these, "A Contribution to the Etiology in Scarlatina in Surgical Cases," by W. E. Paley, was communicated by Goodhart with observations. It was based upon records of Evelina Hospital for Sick Children, and contained the reports of

twenty-five cases. Of these patients, nineteen were shown to have been exposed to scarlatina, and of the remaining six, all save one had possible sources of infection. Goodhart, however, was careful not to assert that all such red rashes should be attributed to scarlatina. The scarlatinous nature of the cases reported in the paper will be everywhere admitted. The second paper was by House, and is based upon four cases of surgical scarlatina, occurring epidemically in Guy's Hospital. The epidemic ceased upon the establishment of isolation, and its scarlatinal nature cannot be doubted. While this author does not venture to affirm that there is *not* "such a thing as a rose rash in a typical case of septicæmia," he believes "that the more these cases are studied, especially when the disease occurs in groups of cases and in patients that have been dressed antiseptically, the deeper will become the conviction that they have little in common with true septicæmia, and that they all originate in the first place in a true scarlatinal infection." Riedinger,\* who reported ten cases of scarlatina after wounds and operations, reached his diagnosis from symptoms, and was only in one case able to trace a contagious influence. He also concluded that there exists in wounded persons a predisposition to scarlatina. At the International Medical Congress of 1881, in London, Mr. Howard Marsh and Riedinger reaffirmed this opinion, and, in the succeeding discussion, Holmes and Goodhart coincided with their views; the former, however, declared that many cases of "surgical scarlet fever" are due really to pyæmia and other causes.† It appears, therefore, that most recent writers decidedly incline to the opinion that these eruptions are generally dependent upon true scarlatina. When any tendency toward epidemic prevalence is shown, every one will agree with such conclusions—as much cannot be said of these rashes when occurring in isolated cases. Broadly speaking, all debilitating causes predispose those influenced by them to

\*Read before the American Dermatological Association at Greenwich, August 26, 1886.

†From the Journal of Cutaneous and Venereal Diseases.

‡Le Progres Medical, Sept. 14, 1878.

\*Centralb. f. Chirurg., No. 9, vii., 1880, 134.

†See Transactions, vol. iv., p. 177.

attacks of infectious disease. Is this more especially true of scarlatina?† A glance at Paley and Goodhart's figures is instructive. Of twenty-five cases observed, scarlatina attacked seventeen after operation; seven of them were without any wound whatever, and one had an old sinus only. Many of the cases of other writers had no external wound whatever. Unfortunately, reporters most rarely note whether their patients had ever previously had scarlatina. Most children, when first exposed to the contagion of this disease, become infected; is it remarkable that they are unable to withstand it when it attacks them weakened by injury or surgical operation? Trent, indeed, reasoning from imperfectly considered and insufficient data, has concluded that scarlatina is less apt to attack surgical cases than others.§

But, apart from epidemic influences, it is probable that scarlatiniform eruptions in the wounded may justly, in a large proportion of cases, occur quite independently of scarlatina. Rashes of septicæmic origin are well known to occur. Various fugitive eruptions often develop under nervous irritation of indifferent origin, as when they proceed from certain topical influences, or from various ingesta, whether as food or medicines, or, finally, from strong emotional disturbance. Urticaria and erythema not rarely follow surgical operations. Spencer Wells has seen a rash like that of scarlatina cover a woman's body in less than a quarter of an hour after the application of perchloride of iron to a cauliflower excrescence of the uterus. One patient always developed urticaria upon the introduction of the speculum.\* Such idiosyncrasies are not uncommon.

The rashes of septicæmia are, it is true, usually urticarial in character, but often enough are erythematous, when they appear as large plaques, mingled or not with urticarial wheals, scattered irregularly over the body and of uncertain duration. It must be admitted that true scarlatiniform septicæmic rashes

are not common.† But there seems to be excellent evidence that they do occur. How, otherwise than upon a theory of sepsis, using the term in a broad sense, are we to account for such cases as the following: Konetsche‡ treated a boy nine years old for compound fracture of both bones of the leg. The wound was dressed antiseptically as far as practicable. Two days after the injury (Aug. 14), the temperature was 40° C. (104 F.), and there appeared over the whole surface an exquisite scarlatiniform eruption, which was intensely red on the next day, and showed numerous miliary vessels. This lasted six days and was followed by lamellar desquamation. Again on Aug. 26 the temperature rose (39.5° C.), and the scarlatiniform rash again appeared, lasting, however, only two days. Decided scaling again followed. Elevated temperature was again noted on Sep. 3d (39.2° C.), and a very characteristic rash again developed, lasted four days, and again desquamation followed. There was at no time angina or swelling of the submaxillary glands. There was no scarlatina in the neighborhood, and no extension of the disease took place. Equally discordant with a theory of scarlatinal origin is the following case reported by Ffolliott:§ A private soldier of the garrison of Ali Musjid was burnt in an explosion of gunpowder on the face and arms and on the left hip and internal surface of the thigh. On December 25, four days after the accident, he had considerable constitutional disturbance, and a bright scarlet eruption appeared upon the belly. By the next day his whole body was as red as a boiled lobster. The temperature, at first 101° F., fell as the eruption developed. This disappeared in four or five days and was followed by general desquamation. The disorder was regarded as scarlatina by several medical officers. But the man had been three years in India; there was no scarlatina in camp, and Mr. Ffolliott had not seen or heard of a case in

†It is remarkable that a scarlatiniform rash is apt to follow lithotomy. Thomas Smith saw it seven times in forty-three lithotomies. Maunde, Broadbent, Callender, and others have seen it. Curiously, the rash in these cases often begins around the wound.

‡Wien. Med. Presse, 23, 1882, p. 1483.

§Brit. Med. Jour., 1, 1879.

†Paley's figures show a like predisposition to measles under similar conditions.

§Centralbl. f. Chirurg., No. 18, vii, 1880, 291.

\*Consult also Batut, These de Paris, 1882, No. 349.



twelve years' service in India. More over, scarlet fever is a disease practically unknown in that country.\* Attempts have been made to establish a differential diagnosis for this surgical rash. Cheadle,† for example, claimed that in "surgical erythema" (1) there is no swelling of the tonsils, no enlargement of the glands, though the fauces may be reddened; (2) the strawberry tongue is absent; (3) the rash is not often universal, but is confined to the body and parts covered with clothes, the face remaining uninvolved; the eruption rarely lasts twenty-four hours, and is never followed by desquamation. These points are of no value. George May, Jr.,‡ thought he could diagnosticate the non-scarlatinous surgical eruption by the absence of the boiled-lobster appearance of the skin and by the mild lingual and faucial symptoms. Subsequently, however, he candidly admitted that the case that had served as a text for the expression of this opinion turned out to be one of true scarlatina.

A final etiological factor in the production of scarlatiniform eruptions is the ingestion of various drugs. These eruptions have received from numerous writers passing reference in this connection, but by no means the attention to which they are entitled. Scarlatiniform rashes may be evoked by the ingestion of belladonna, copaiba, opium, and morphia, chloral, mercury, and other drugs, but, above all others, as bearing upon our present subject, of cinchona and its alkaloids. These preparations are those most frequently given to persons who have been injured or subjected to surgical operations, and, beyond question, eruptions induced by them are often attributed to other causes. The quinine eruptions are only beginning to receive due attention, and are much more common than is generally supposed. They usually show the features of urticaria or simple erythema, and are associated with an interesting series of general phenomena. Other eruptive forms are also observed, but the one that concerns us at present is the scarlatiniform rash.

This is not especially uncommon, and doubtless many obscure cases of "idiopathic," and "septicæmic," and "surgical" scarlatiniform rash should be properly attributed to it. This rash has been described now by many writers, among whom may be mentioned Bussy,§ Levassor,|| and, more especially, Morrow.¶ It may exactly resemble scarlatina. Persons possessing the idiosyncrasy often develop it after the smallest doses of the drug. At the onset it often cannot be distinguished from scarlatina. Beginning with high fever, and often with sore throat, the eruption appears upon the chest, face, and neck, and within twenty-four hours the entire surface presents the bright scarlet color that resembles that of a boiled crab or lobster. At the end of this period the resemblance may be made perfect by the appearance of the "strawberry tongue." Up to this point, in default of a knowledge of the patient's idiosyncrasy, the diagnosis may remain impossible. Rarely it remains so throughout the attack, especially when the ingestion of the cinchona preparation is continued. Usually, however, after thirty-six to forty-eight hours the type of normal scarlatina is departed from. The fever rapidly decreases; the angina, which has never been proportionate to the other symptoms, disappears, and the rash either begins to fade or to acquire features unlike those of true scarlatina. It becomes duller in color, more papular in character, and often shows a tendency to form milium vesicles. Eventually, it may come to resemble ordinary "prickly heat." Such a course, however, is by no means always pursued, and the scarlatinoid features are preserved. In either case, a copious desquamation is sure to follow. This is usually lamellar and may show a glove-and-slipper-like exfoliation of the epidermis of the hands and feet. Even albuminuria has been known to add to the embarrassment of the diagnostician. The writer has several cases in mind and is convinced that a closer scrutiny will lessen the number of so-called "idiopa-

\*Hirsch, "Historisch-Geographische Pathol."

†Brit. Med. Journal, ii., 1879, p. 75.

‡Brit. Med. Journal, ii., 1878, 919.

§These de Paris, 1879.

||These de Paris, 1885.

¶New York Medical Journal, xxxi., 1880, p. 244.

thick scarlatiniform erythema," of "septicæmic scarlatiniform rash," and of isolated "surgical scarlatina," by enabling the observer to assign them to their true cause.

The foregoing considerations would seem to justify the following conclusions:

1. Unprotected persons who have suffered injury, or who have undergone surgical operations, are rather more liable to scarlatina than the unprotected healthy. This increased liability is probably due to diminished power of resistance from disease, and will probably hold with regard to other specific fevers. Scarlet fever is more apt than the other exanthemata to attack such persons, because its influence is usually more widespread, and because it varies within such wide limits that it often escapes the attention of those who readily detect other infectious disorders, and provide against them.

2. When an epidemic tendency of the symptoms we have been considering to prevail after injuries and operations is shown, it may be concluded with confidence that true scarlatina is present.

3. Septicæmia is occasionally accompanied by a scarlatiniform rash which does not depend upon the scarlatinal poison.

4. Medicinal eruptions, especially those from cinchona and its preparations, not infrequently follow injuries and operations. These rashes are probably for the most part usually attributed to true scarlatina or septicæmia.

In obstetrical practice, scarlatina is unquestionably capable of exerting a most noxious influence, but as the distinctly scarlatinal symptoms are here decidedly less important than the obscure and dangerous systemic symptoms that the virus seems to induce, the writer does not presume to enter upon the discussion of this branch of the subject before this Association. He inclines strongly to the opinion, however, that in so far as concerns a distinctly scarlatinal rash in these cases, the line of argument followed in this paper is equally applicable.

## Hospital Reports.

### PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

BY JULIAN J. CHISOLM, M.D., SURGEON IN CHARGE.

(Monthly Report for September.)

During the month of September the attendance at the hospital was 2,335, an average of 90 persons for each working day of the month. 551 new cases applied for treatment.

During the month 123 operations were performed at the hospital, of these 17 were for cataract. The oldest case was a female aged 90 years, who had been blind in one eye from cataract for six years. She was becoming blind in the other eye. Her general health was good. The operation for cataract extraction was performed painlessly under the influence of cocaine. After the operation the closing of the eye lids by a piece of adhesive isinglass plaster was the only dressing. At the end of five days the adhesive straps, which had been applied on the day of operation, were removed, and the patient found herself at once with good vision and an eye which could bear ordinary light without annoyance. By the end of seven days, or one week from her admission into the wards, she was walking about freely with good sight, having had no pain at any time from the moment of operation.

This new dressing for eyes after operations, a bold departure from established methods, and one which has created such a revolution in eye surgery, was commenced at this Presbyterian Hospital May last. Its great superiority over the stereotyped method of eye dressings in universal use, has caused bandages and compresses, and with it dark rooms, to be discarded from this hospital. The advantage of the isinglass plaster strips was brought to the attention of the profession first in the Presbyterian Hospital report for the month of June, as published in the MARYLAND MEDICAL JOURNAL. This was followed by more extensive papers in the *American Journal of Ophthalmology*, for June, and the *New*



*York Medical Record* for July 31, 1886. This rational mode of treatment was received at once with favor. It is revolutionizing the after treatment of cataract patients in the United States, and is commencing to do the same good thing for Europe. My article in the *American Journal of Ophthalmology* was headed "The Rational Method of Treating Cataract Patients, to the Exclusion of Compresses, Bandages and Dark Rooms." The following statement was made in this paper as the result of my experience. "I could for myself safely say that the revolution in the after treatment of cataract, and iridectomy patients in the Presbyterian Hospital is complete." "From this time hence all bandages, compresses, and dark rooms will be things of the past, to be remembered only by the discomforts which they occasioned." A recent article in the last number of the *London Lancet*, (Sept. 18th) is from an ophthalmic surgeon of large experience in the English hospitals. He writes that having read the article in the *American Journal of Ophthalmology* he was attracted by its subject and concluded to try it for himself. After ample experience he was so fully able to endorse my results, that he adopted my heading for his article and winds up his strong paper with my conclusion: "From this time hence all bandages, compresses and dark rooms will be among the things of the past in my hospital." One journal after another has taken up the good news and have spread it far and wide, so that the blind in all parts of the world will be released from the thralldom of darkness and bandages, their greatest horror after eye operations. Cocaine now allows cataracts to be removed without pain, and with no risk whatever to life. The new, simple, light dressing, with light rooms makes the after treatment as comfortable as the operation, because it removes all necessity for confinement in bed. To be released from the restraints which all ophthalmic surgeons thought themselves forced to practice upon cataract patients, for their supposed well being, is a revolution indeed, second only to the introduction of cocaine into eye practice.

Correspondence.

A FORMULA FOR CORYZA.

BALTIMORE, October 2, 1886.

To the Ed. *Maryland Medical Journal*:

DEAR SIR:—In a September number of the MARYLAND MEDICAL JOURNAL, I see on page 439, a remedy for coryza.

I have found the following formula very efficient.

R Acacia pulv. - 3 ij,  
Bismuth sulph. - ʒij,  
Oleum. cinn. - gtts. ij.

M. To be taken as snuff.

Yours truly,  
D. GENESE, D.D.S.

Society Reports.

THE AMERICAN GYNÆCOLOGICAL SOCIETY.

THE ELEVENTH ANNUAL MEETING HELD  
IN HOPKINS' HALL, JOHNS HOPKINS  
UNIVERSITY, BALTIMORE, MD.,  
SEPT. 21, 22, AND 23, 1886.

(Continued from last issue.)

Wednesday, Second Day, Morning  
Session.

Dr. John Goodman, of Louisville, Ky., presented a paper entitled

ERGOT AFTER LABOR.

In the absence of the author the paper was read by the Secretary.

The administration of a full dose of ergot immediately after the completion of labor has become a general practice. It is claimed that it promotes involution, prevents after-pains and tends to prevent post partum hæmorrhage. Some years ago, the author administered a full dose of ergot after a perfectly normal labor. In fifteen minutes, severe pain appeared and increased. The tenderness in the uterus continued for a week. There was no milk and the patient pre-

viously prolific, never again conceived. The trouble was attributed to inflammation of the muscular coat of the uterus produced by the action of the ergot.

In a second case ergot was given after a forceps delivery. On the seventh day the patient had a chill followed by a temperature of 104. The next day a clot was washed out of the uterus and the temperature fell to 99. Well marked septicæmia developed and the patient died one week later. In this case the retention of the clot was attributed to the spasmodic contraction of the uterus preventing its escape. The author had seen other cases in which injurious effects were produced by the administration of ergot.

He claimed that ergot did not assist involution, which was a natural process and required a certain length of time for its completion. That we have in ergot a remedy capable of arresting after-pains cannot be doubted, but it does so by exciting a mode of muscular action at variance with all physiological laws. After-pains are conservative and its better to wait until they become of abnormal severity before resorting to treatment. Ergot is capable of preventing hæmorrhage, but its use is attended with such dangers that it should not be employed except under exceptional circumstances. It should be an inviolable rule not to give ergot at the close of the third stage of labor, unless hæmorrhage is eminent. It should then be used by hypodermic injection.

#### DISCUSSION.

The President, *Dr. Thaddeus A. Reamy*, of Cincinnati. I have in process of preparation a paper in which I enter my protest against routine practice of the administration of ergot after the third stage of labor. This conclusion is based upon my experience and upon a study of the action which is claimed for the drug, the contractions produced by ergot are unlike those of nature. The contraction of ergot is persistent, while the normal contraction is intermittent. If the contraction is persistent, the circulation of the uterine wall cannot reach

a healthy state and thus in the process of contraction it not only retains what is in the uterine cavity but it interferes with the process of involution and lays the foundation for sepsis and inflammation. I think that in the course of the next five or ten years, the practice of obstetricians in this matter will be revolutionized.

*Dr. William Goodell*, of Philadelphia. The author of the paper states that it is only since last May that he has given up the use of ergot. I think that he has not had sufficient time to form such positive opinions. In the first case, I think that there must have been a fibroid tumor. The second case was a clear instance of septicæmia. I do not think that after pains are conservative. As a rule we do not see them in primipara. I do not believe that every woman who has given birth to a child needs ergot, but we do not know the cases which do require it. In twenty-five hundred cases of labor, I have always given ergot after the completion of labor and I have never seen any harm from its use. I do not believe that one dose of ergot has much effect in favoring involution. Involution is the result of fatty degeneration and the greater the contraction the greater the interference with the circulation and the more rapidly should this change take place. I have used ergot for two purposes, one was to prevent hæmorrhage and the other to prevent the absorption of septic matter. Since the introduction of antiseptics, which I think should be used in every case of labor whether public or private, the use of ergot to prevent septic infection is not so important. I think that it does not do the harm which has been mentioned.

*Dr. George J. Englemann*, of St. Louis. I hold in the main the views which the President has expressed. I use ergot much less than I did a few years ago. I believe that we have equally effective measures in the hot antiseptic douche and in the faradaic current. After the contents of the uterus have been expelled ergot will in certain cases always be a useful and effective remedy. I would not venture to say that before



the contents of the uterus are expelled, it should not be used at all.

*Dr. Theophilus Parvin*, of Philadelphia. The effects of ergot vary with the dose. A small dose acts simply to increase the normal uterine contractions. I must object to the assertion that ergot should never be given before the completion of labor. Statistics show that those who are most successful in the treatment of placenta prævia are the men who use ergot. Again in a multipara, with the os dilated, where a sudden rupture of the membranes has taken place with a cessation of labor, fifteen or twenty grains of ergot causes a rapid completion of the labor. After a protracted labor, there is a weariness of the uterus and a failure to enter upon the normal retraction which is a preventive of hæmorrhage and tends to promote involution. As long as in the third stage of labor we assist nature in the expulsion of the placenta, why should we not assist nature in securing normal retraction of the uterus after the completion of the third stage? In some experiments which I made at the Philadelphia hospital to determine the rapidity of involution of the uterus in women who had received ergot and in those who had not, it was found that in those who received ergot after delivery, uterine involution seemed to take place more rapidly.

*Dr. Skene*, of Brooklyn. I have never seen such effects from ergot as have been described in the paper. I do not think that in the cases reported, the ergot had anything to do with the production of the effects. All rational men use ergot as any other remedy; when it is necessary or may possibly become necessary if there is any doubt whether or not it is needed, it is better to give the patient the benefit of the doubt.

*Dr. P. C. Williams*, of Baltimore. I believe that ergot has its place in obstetrical medicine. I have never yet regretted its use in any case, but I have regretted not using it. The great danger under the use of anæsthetics is hæmorrhage. To avoid this the use of ergot seems to be the proper thing. I admit that ergot is abused, but the abuse of er-

got is no argument against its proper use.

*Dr. Thaddeus A. Reamy*, of Cincinnati. The profession is not taught that ergot should be given in diseased conditions, but that it shall be given in all cases after labor as a routine practice and it is only against this use of it that I raise my voice.

*Dr. Thaddeus A. Reamy*, of Cincinnati, read the following

#### PRESIDENT'S ADDRESS.

The speaker first referred to the prosperity of the Society during the past ten years, and spoke of the great advance of abdominal surgery and ovariectomy during the same time. The speaker thought the less satisfactory results obtained in America as compared with other countries, might be due to climatic and constitutional conditions and to the fact that the operation was performed by too many operators. The operation of removal of the ovaries for beginning cystic troubles and for other conditions is performed in many cases which could be relieved by other and less serious measures. The practice of Schroeder in leaving the undiseased ovary was recommended. The success of ovariectomy has led to the performance of laparotomy in other conditions as suppurative peritonitis, with satisfactory results.

The use of electricity as a therapeutic agent is attracting much attention; it is the safest and most effective remedy in extra-uterine pregnancy and it is coming into use in many other uterine conditions.

The treatment of extensive fibroid disease was next taken up. Medical treatment is in the main unsatisfactory, although in some cases good results have followed the use of ergot and electricity, especially the latter, which is perhaps the most effective therapeutic agent in these cases. The operation of hysterectomy, should not as a rule, be performed in these cases. Spaying has met with more favor and success than any other surgical procedure. There are a few cases where on the account of the large

size of the tumor or its fibro-cystic character, hysterectomy probably affords the best hope.

Pelvic deformities were next considered. In the lesser degree, premature labor with the use of appropriate forceps applied with proper skill were recommended. With reference to operative procedures, the mortality in the United States has been very great. An important reason for this is the failure to recognize the importance of early interference. It has also been shown that other things being equal, the danger is increased by doing the operation after the death of the child.

The total extirpation of the uterus for cancer has been steadily growing in favor. So far as the speaker had examined the clinical proof the evidence as to its utility had not been convincing. While patients have recovered from the operation, it is not yet proven that the operation is justifiable, except where the disease is confined to the body of the uterus or the cervix and the vagina is free. While the view that epithelioma of the cervix is due to traumatism is not generally accepted, he believed that traumatism of the cervix was conducive to the development of epithelioma. If for no other reason, Emmet's operation is warranted on the sole ground of a preventitive.

The speaker in referring to the uterine curette, stated that he had recently had alarming symptoms following its use and in one case where the instrument was used immediately after dilatation with sponge tents, death resulted. Peritonitis had not been developed in a single case where the dilatation is alleged to be comparatively free from the dangers attendant upon the use of tents, but he has recently had a high degree of peritonitis following dilatation by this method where the curette was not used.

The following rare case was then described. A married woman aged 32, the mother of two children, had suffered with severe menorrhagia during the past year. There was an old laceration of the perineum, but no laceration of the cervix. The uterus measured three and one-fourth inches and was not ten-

der. No pelvic tenderness could be detected. Treatment directed to the general condition was ordered and under it, the anæmia improved and menorrhagia decreased. Some months later the blunt curette was used with the woman in the lithotomy position. No dilatation was required. A large amount of the fungus tissue was removed from the posterior wall and the curette was then passed over the anterior wall. During the manipulation, no roughness being employed, the instrument passed through the uterine wall. It was at once withdrawn and a sound being introduced it readily passed its whole length, and its extremity could be felt externally above the umbilicus. Forty drops of laudanum was administered by the rectum and an ice bag placed over the abdomen. The ice bag was kept on continuously for five days. The accident caused no symptoms whatever. The perineum was subsequently restored and the woman's health is much improved. The menorrhagia has disappeared.

In conclusion the president referred to the proposition looking to the organization of a Congress of American Physicians and Surgeons, and hoped that the action of the Society would be favorable to such an alliance.

*Dr. Fordyce Barker*, of New York read a paper on

#### THE INFLUENCE OF MENTAL IMPRESSIONS ON THE FŒTUS.

The belief that maternal impressions may affect the nutrition and development of the fœtus in utero has existed from the earliest periods of which there are any records. Medical writers with hardly an exception down to the beginning of the eighteenth century express the belief with more or less distinctness that foetal marks and deformities are due to the emotions, desires or shocks of the pregnant mother. Reference was then made to numerous papers written within the past twenty years in which this theory was strongly controverted. Those who disbelieve this doctrine base their skepticism on what they regard as physiological reasoning and chiefly on the as-



sertion that there is no direct nerve connection between the maternal and foetal systems. Deformities they urge are due to arrest of development; but no one has brought forward sound physiological reasons why this arrest of development may not have been caused by mental impressions affecting the foetal nutrition by their influence on the maternal blood. Extremely rare as is the occurrence of cases which prove the result of this influence, he considered the fact is so well proved by sufficient authentic evidence as to make it as certain as any other fact which cannot be explained by science. The term "mental impression" should include those which have a physical as well as a psychical origin. Five cases coming under the author's observation were described.

The first case was that of a young lady, who at the age of eighteen, had for the first time been taken to the theatre and had seen Southern the actor in part of Lord Dundreary, and she thought and talked of nothing else. This continued several months and under treatment and change of scene, gradually wore away. She subsequently married and four years after her attack of insanity, her first child, a boy, was born. As the child became able to talk he exhibited peculiarities, resembling those of Lord Dundreary. He walked with a little skip, had a slight stammer in his speech and his left brow was drawn over with the lids practically closed.

The second case was that of a lady, a typical brunette who was first married to a gentleman, a typical blonde. She was never pregnant by him. Subsequent to his death she married a gentleman as marked a brunette as herself. Her first child was a decided blonde. Both her own and her husband's relatives are all brunettes. The lady has since had three children all brunettes.

The third case was that of a lady who during the first month of pregnancy had been much worried over her oldest daughter who had had her ears bored for rings. The ears became inflamed and caused much trouble. When the child was born both ears presented the appearance of having been pierced for

rings, and through at least one of the lobes, a thread could be passed.

The fourth was that of a lady who at a very early period of pregnancy was much impressed by seeing three ladies, all of whom had hare-lips. When her child was born it had a double hare-lip.

Case fifth, Mrs. X., married but a few weeks, was at the theatre with her husband. Something vexing him he placed the point of his elbow on her hand and held it so firmly that she could not draw it away. Not wishing to make a scene, she bore it until she fainted. The fingers were much swollen and painful for several days. She never lived with her husband afterwards. Thirty-five weeks and three days after the theatre incident, she gave birth to a son. On the left hand, the first and second phalanges of all the fingers and thumb were absent, looking as if they had been amputated. During her pregnancy, she had never thought that her child would be born with any deficiency.

Other reported cases were then referred to.

#### DISCUSSION.

*Dr. William Goodell*, of Philadelphia. I have been very sceptical on this subject, but I have seen one case which seems to bear out the theory. A physician was called upon to assist at the operation of circumcision. His wife, who was in the early months of pregnancy was much interested in the operation and insisted upon hearing all the details. The operation and its cruelty occupied much of her thoughts. When her child was born, a boy, it was found that the glans was exposed, the prepuce well retracted with granulating edges, showing the appearance very similar to that of a recent circumcision.

I have recently seen an almost identical condition in a child, which could not be accounted for by any impression on the mind of the mother.

*Dr. Samuel C. Busey*, of Washington. While I have no positive convictions to present, I believe that there is some relation between mental impressions and foetal deformities. Any prevalent and concurrent belief must be based upon an

element of truth. This belief has prevailed since the time of Jacob. At the present time it is a fixed belief in the female mind. In the physical world there is no effect without a cause and in the world life the rule is the same. If we can demonstrate in any single instance between the deformity and the mental impression, we must concede that such a thing can again occur. If there are any number of cases where we can show a precise correspondence between the impression and the deformity, the relation must be accepted as presumptively proven. Dr. Barker has cited some instances and Dr. Goodell has given another case. In another case the mother pregnant saw a man with an opening in his trachea from which a tracheotomy tube had been removed. The child when born exhibited a depression in the same position. Another case is reported where the mother received two distinct impressions and the child was born with two distinct deformities corresponding to the separate impressions received. In another case, the father had removed in the presence of his mother, a metatarsal bone of one of the fingers. When the child was born it exhibited a corresponding deformity. A consideration of these cases can bring us to but one conclusion. The earlier in pregnancy the impression occurs the more frequently does the deformity follow and the greater is the correspondence between cause and effect.

*Dr. John S. Billings*, of Washington. There are many cases on record which cannot be explained by any knowledge which we now have. As to the influence of previous pregnancies on the characteristics of subsequent pregnancies, we have no scientific information. If we could obtain the statistics showing the characters of children born of different fathers we should have some scientific data on which to form an opinion.

*Dr. Fordyce Barker*, of New York. In all the cases I have reported there is no evidence that the period since conception has been more than six weeks. I have selected all cases in which conception occurred three or fourth months before the mental impression was produced.

AMERICAN PUBLIC HEALTH ASSOCIATION.—*Fourteenth Annual Meeting*. 1886.—The American Public Health Association convened at Toronto, Canada, Tuesday, October 5, at 10 o'clock A. M., and continued in session four days. The meetings were held in Shaftesbury Hall, on Queen Street, West. The Executive Committee had selected the following topics for consideration at said meeting:

I. The Disposal of the Refuse Matters of Cities and Towns.

II. The Condition of Stored Water-Supplies, and their Relation to the Public Health.

III. The best Methods and the Apparatus necessary for the Teaching of Hygiene in the Public Schools, as well as the Means for securing Uniformity in such Instruction.

IV. Recent Sanitary Experiences in connection with the Exclusion and Suppression of Epidemic Disease.

V. The Sanitary Conditions and Necessities of School-Houses and School-Life. (Lomb Prize Essays.)

VI. The Preventable Causes of Disease, Injury, and Death in American Manufactories and Workshops, and the best Means and Appliances for preventing and avoiding them. (Lomb Prize Essays.)

VII. Plans for Dwelling-Houses. (Lomb Prize Plans.)

Upon the above topics a good number of able papers were presented by well-known sanitary writers. Authors from several sections of the United States, Canada, and England were present with papers. In addition to papers upon the selected topics, several upon miscellaneous sanitary subjects were presented on the approval of the Executive Committee, and assigned a place on the programme.

The police authorities in Berlin have published an order requiring physicians to give written notice to the sanitary board within twenty-four hours after the diagnosis of the disease, in every case of puerperal fever, whether followed by death or not. The name of the midwife in attendance is also to be given.



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BALTIMORE, OCTOBER 9, 1886.

**Editorial.**

INCREASE IN THE PATENT-MEDICINE TRADE.—To anyone who has observed the advertising columns of the press of this country it must appear evident that the business of manufacturing patent-medicines is largely on the increase.

That these numerous so-called remedies find ready sale and consumption can hardly be doubted. Almost every practicing physician encounters among his patients a large number of people who use in one way or another one or more of the numerous "cure-alls" presented to their notice, and whilst the majority of these people profess to have no faith in them they nevertheless manifest a willingness to give them a trial. The idea prevails, to a wide extent, that such remedies do no harm, even though they do no good, and believing in this fallacy many people readily yield to the experiment of indulging in a bottle or two.

The manufacturer of a patent nostrum knows this fact and he is well satisfied if one citizen out of every fifty will give trial to one bottle or package of his "cure-all." An annual consumption of one million bottles of a nostrum will handsomely pay for the enormous expenditure of printer's ink upon the part of the manufacturer and leave a large surplus for his enterprise. It is safe to say that the cost of the remedy is not over 15 per cent., the outlay for advertising averages about 35 per cent., leaving a margin to the manufacturer and vender,

wholesale and retail, of 50 per cent., a profit with margin enough to satisfy the cupidity of the average man of business. The increase in the patent-medicine business is thus satisfactorily explained. The business pays handsomely and capitalist of a certain order are willing to embark in the manufacture of any article which will sell at a fair margin. To succeed as a manufacturer of a nostrum enterprise, boldness and skill are essential. The article must have an appropriate name and must profess to cure such pathological conditions as are known to be incurable by any remedies now known to the scientific world. The remedy must likewise be introduced to the public in the most inviting literary style, with striking phrases and imaginative embellishments. The main point is to impress the public mind with the miraculous value of the remedy and the remedy becomes at once a salable article. The patent-medicine manufacturer has a keen knowledge of human nature. He understands that the world contains fools and he addresses his appeals to these people. In many respects he resembles the shrewd quack and the unscrupulous doctor, both of whom thrive by their wits and keep for sale just the article which the foolish sick patient imagines he wants. Despite the great intelligence of our age there are enough fools in the world to support a good sized army of patent-medicine venders, quack doctors, and others of their kind. In Great Britain and Ireland, in 1885, there were no less than 20,279 venders of patent-medicines. It would be difficult to estimate the number in this country, but if they exist in equal proportion over the entire country to their number in this city, 50,000 will scarcely compass the extent of their existence.

THE MEDICAL PROFESSION IN MARYLAND.—We have recently received a Directory of the Physicians of the United States, published by Polk of Chicago. This work has been compiled with extraordinary care, and is the most complete index of the profession of this country we have ever seen. According to this Directory there are 85,671 physi-

cians in the United States, or about one in 650 of our population.

This rate for the entire country is enormously large, but when we come to Maryland we find that our state is the most crowded of any state in the Union, having but 329 people for each physician. We have always thought our state well supplied with physicians, but we confess to some surprise when we found that she stood at the head of the list.

It is wellknown all over the country that we are an exceedingly hospitable people and generally make it pleasant for all who come to dwell in our midst. Physicians as a class appreciate hospitality and undoubtedly enjoy courtesies extended to them. On this ground we are prepared to understand how it is that Maryland possesses such a large population of medical citizens. Again, our state has a fine climate, refined society, exceedingly handsome women, the very finest oysters, fish and fowl, with other luxuries of the table in great abundance. The physician being a man (or woman) of taste is most willing to hold his (or her) citizenship in a state so bountifully favored as Maryland. Reason number two satisfactorily accounts for the super-abundance of physicians in our state. A third fact still further accounts for the popularity of Maryland as a place of residence for practitioners of the healing art. We are an easy going people, do as we please and let others do as they please. The law recognizes that every citizen has his rights to eat what he pleases, drink what he pleases and to employ what ever doctor he pleases. Every citizen is the custodian of his own health, and he is supposed to be a stupid fellow if he does not exercise this right. He must be a very ordinary citizen if he does not think he knows as much about hygiene, malaria and other matters medical as the average doctor. Constant association with doctors has almost convinced many of our wisest citizens that they know as much medicine as the doctors themselves. In this free country every citizen can be his own doctor, hence many are so considered without having the M.D. attached. The law recognizes any citizen as a doctor,

provided he claims to be one. Many citizens claim this privilege and exercise it with intolerance. Again there are a large number of "perambulating doctors." These doctors find it too unhealthy to reside permanently in any of our sister states, but the climate in Maryland is so mild and genial, living is so luxurious and cheap, the people are so patronizing and affable to strangers that they instinctively succumb to the influences which oppress them and remain here as permanent residents. Upon the whole no other state in the Union offers such attractions to those who are, or would be doctors, and we therefore now readily understand why Maryland is so preëminent in her medical population.

THE RECENT CONFERENCE WITH REGARD TO THE FORMATION OF A CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.—In accordance with a proposal emanating from the American Surgical Association, looking to the organization of a Congress of American Physicians and Surgeons to be composed from the principal specialist societies of the country, committees from the several societies appointed for the purpose met at Washington last week and held a conference.

Among the gentlemen who were present were the following:

From the American Surgical Association, Drs. C. H. Mastin, Mobile; J. Ewing Mears, Philadelphia. From the American Climatological Association, Drs. Frank Donaldson, Baltimore; W. W. Johnston, Washington. From the American Laryngological Association, Drs. F. I. Knight, Boston; E. L. Shurley, Detroit. From the Association of American Physicians and Pathologists, Dr. Wm. Pepper, Philadelphia. From the American Neurological Association, Drs. L. C. Gray, Brooklyn; J. Van Bibber, Baltimore. From the American Otological Association, Drs. C. R. Agnew, New York; W. H. Carmalt, New Haven, Conn. From the American Ophthalmological Association, Dr. O. F. Wadsworth, Boston. From the American Dermatological Association,



Drs. H. G. Piffard, New York; G. H. Tilden, Boston. From the American Gynecological Association, Drs. S. C. Busey, Washington; J. R. Chadwick, Boston; Jos. Taber Johnson, Washington.

Dr. J. Ewing Mears was made Secretary, and Dr. S. C. Busey, of Washington, Chairman. Resolutions were presented by Dr. Wm. Pepper, to the following effect.

(1) That it was advisable to hold a conjoint meeting of the special societies in Washington during the month of September, 1888, and subsequently at intervals of three years.

(2) That the Societies be invited to elect each a representative to the Executive Committee of the conjoint assemblage, who are to have power to complete organizations by electing a President, Secretary and framing By-Laws, etc.

(3) That the conjoint meetings shall take place on two successive evenings, on the former there shall be an address, on the latter a topic for discussion.

(4) That in every respect the Societies shall retain their autonomy and carry out their own programmes.

(5) That any Society can withdraw at any time.

### Miscellany.

THE INTERNAL TREATMENT OF GONORRHOEA.—At the meeting of June 21st, of the Berlin Society of Internal Medicine, a discussion arose upon the treatment of gonorrhœa by medicines.

Dr. Posner stated that, although what had been learned about the gonococcus was extremely interesting, it had not given us much that was practical so far as treatment was concerned.

Local anti-bacterian treatment has not yet been followed by brilliant results, and to-day we treat gonorrhœa with the well-known remedies, and combat it especially with the various forms of injection. These injections are not valuable in that they destroy the gonococci, but because they cure the inflammation of the mucous membrane. Internal medi-

cines act beneficially by passing off in the urine and clean out the urethra in the opposite direction from that in which local treatment acts.

He speaks highly of sandal-wood oil, which has had such a reputation in France, and which he has used much because he has become convinced that injections, although they work so well in some stages of gonorrhœa, still are not well borne by many patients, and can indeed act injuriously. From the speaker's observation he believes that many gonorrhœas which would get well of themselves under suitable regime are often kept up artificially.

He has used the sandal wood in fresh cases, and can state from his own observations that under all circumstances it was better borne than the other balsams, and that under all conditions it exerted a better influence on the disease.

In those complications of gonorrhœa in which we have to cease injections, on account of epididymitis, cystitis, prostatitis, etc., this drug is greatly to be recommended.

Repeatedly had Dr. Posner seen cases of acute catarrh of the bladder, with bloody or turbid urine, improve and the urine become clear after a few doses of the sandal-wood oil. In old cases of cystitis and prostatitis, it is also beneficial and always acts favorably on the tenesmus, and clears up the urine. In chronic gonorrhœa, less stress is laid upon its beneficial action. The purity of the preparation is of great importance. The most elegant form to use is the French preparation which goes under the name of "santal midi," put up in capsules which are easily taken and well borne. The patient takes daily from ten to twelve of the capsules of five drops each. A German preparation on the market, also in capsules, does not agree so well with the stomach. If the oil does not agree with the patient, a little hydrochloric acid may be added to the dose, and, to improve its taste, a few drops of oil of peppermint.

Altogether, according to the speaker's idea, sandal-wood oil is the most efficacious internal remedy at our disposal.

Dr. Lublinski has had occasion to use

sandal wood since his attention was called to it from English sources, some four years ago, and he agreed with Dr. Posner as to its value. It does not affect the stomach nearly so much as balsam of copaiva, but its action is not so strong as the latter drug. He has increased the daily dose gradually to twenty capsules. When administered in drops, he gives peppermint tablets with it. In severe tenesmus, even when the bladder is affected, he has found it to work admirably.

Dr. Rosenthal had also used sandalwood, but when a decided result was not obtained, he was better satisfied with the old balsam of copaiva. It is desirable to have the drug remain as long as possible in contact with the mucous membrane of the urethra. When the disease is in the posterior part of the urethra, in the neighborhood of the neck of the bladder, balsam of copaiva has an especially favorable action, but if the gonorrhœa is in its first stage the result is not so good. He does not altogether agree with Dr. Posner that no injections are necessary. That balsam of copaiva has an action on the gonococci is shown by a recent work of Oppenheimer. The gonococcus does not grow when placed in the urine of a man who has been taking the balsam. When gonorrhœa reaches the neck of the bladder all injections must be withheld, and at this time he has found balsam of copaiva the best remedy.

Dr. Caspar also confirmed in all essentials Dr. Posner's observations. He had first learned of the use of the drug in England two years ago, and had since made frequent use of it. He finds, however, the dose given by Posner rather large, and uses himself only a ten-drop dose three times daily. The East India sandalwood is that most to be recommended.—*Deutsche Med. Zeit.*, July, 1, 1886.—*Jour. Cut. and Ven. Dis.*

**EXTIRPATION OF THE UTERUS.**—Herr Brennecke (*Zeitschr. f. Geburtsh. u. Gynæcol.*) publishes eighteen cases of total extirpation of the uterus, for malignant disease, without a death. There are four main points to be kept in view in the performance of the operation:

1. Complete accessibility of the field of operation during every part of it. In addition to the ordinary instruments, he uses a specially constructed clamp for drawing down the uterus.

2. There must be full control over any possible hemorrhage. The posterior and anterior vaginal arches are opened by a knife made like Küchenmeister's, after which the cervix is shelled out, before and behind, from the loose surrounding cellular tissue. In the same way he shells out the firmer lateral paracervical connective tissue about its back and front. When this is done it is not difficult to ligature the lateral appendages of the uterus. For this purpose he uses a strongly Scurved needle, like Ols-hausen's, for introducing the ligatures. After the appendages are made safe, he retroflects the uterus as far as possible. In this way, the vesico-uterine fold of the peritoneum is most safely divided without injuring the bladder. Finally, the broad ligaments on each side are inclosed, each in an elastic india-rubber ligature, and the uterus is separated from them, proceeding in the manner just sketched out.

3. Injury of neighboring important organs is most securely avoided.

4. The mode of operation and the after-treatment offer the surest possible guarantee for an aseptic course, undisturbed by accidental influences. The after-treatment is very simple, as the operator refrains from all superfluous manipulation. He neither drains Douglas's pouch, nor makes use of sutures. A glycering-iodoform tampon and the ligatures provide sufficiently for drainage. When the tampon is removed, in the course of six or seven days, simple vaginal irrigation is enough.

As regards the indications for the operation, Herr Brennecke prefers total extirpation to amputation of the cervix in carcinoma of that part, as high cervical amputation is more bloody and less safe than total extirpation.—*Medical Press and Circular*.

**THE RELATIVE VALUE OF VARIOUS DISINFECTING AGENTS.**—The infection of a wound during an operation springs



either from its contact with hands not freed from micro-organisms, instruments, sponges, etc., or from the entrance of bacteria from the non-sterile atmosphere of the operating-room. The former source of infection is by far the more important one.

In order to experimentally ascertain the relative value of the most popular disinfecting agents, Dr. Kümmel, of Hamburg, brought sponges, instruments and other utensils of the operating-room in contact with Koch's gelatin-plates, and noted the number of subsequently formed colonies after using the various modes of disinfection (*Archiv. für Klin. Chirurgie*, 1885, xxxiii. 3, p. 531).

Kümmel noted very essential differences between the cases in which the disinfection had been preceded by washes of potassium soap and those in which this precaution had not been taken.

Instruments taken from a cupboard, in which they had remained for some time, but free from every visible soiling, could not be sterilized by an immersion into a 5 per cent. solution of carbolic acid, lasting two minutes. A contact of ten minutes with the solution, however, sufficed to kill all germs.

Other antiseptic agents, such as the sublimate soap, gave still less favorable results. The 1 per cent. Hg soap did not produce any reliable sterilization in fifteen minutes.

On the other hand, knives used in the dissecting-room and exceedingly soiled were rendered almost completely sterile by simply washing them with water and potassium soap. Complete sterilization could invariably be looked for by an immersion into a 5 per cent. solution of carbolic acid after the preceding use of the potassium soap. The same held true of sponges; disinfection without the preceding use of the potassium soap was uncertain and required ample time, while following its use it was both reliable and quick. The hands presented greater difficulties to a complete sterilization than either knives or sponges. Potassium soap and a 5 per cent. solution of carbolic acid by far excelled, also a 1 per cent. sublimate solution.

Kümmel also endeavored to sterilize the air of a room before and during an operation, but, as could be expected failed completely. A spray being in action for some time did not even diminish the number of germs in existence, and only after the apparatus had ceased to work, the colonies were noted to have somewhat decreased. Very good results were obtained by thoroughly washing the walls and all furniture in the room.—*Ther. Gaz.*

NOTHNAGEL ON THE TREATMENT OF PERICARDITIS.—Professor Nothnagel, of Vienna, in a clinical lecture on the treatment of pericarditis, advises that in cases where there is pain in the cardiac region, fever, and the commencement of exudation, leeches varying in number from three to ten, according to the gravity of the symptoms and the constitution and strength of the patient, should be applied. The leeches should be renewed every four or six days. Cupping may be substituted, but leeches are preferable. An ice-bag should be applied, or a directing apparatus through which cold water can be constantly applied to the part. Cold compresses are of no use unless they are laid on ice, and then they must be changed every five minutes. Digitalis for internal use is indicated under certain circumstances. It is useful if the cardiac action is greatly increased, especially if there are signs of the heart muscle becoming implicated, when it should be given in somewhat larger doses. Digitalis is not desirable in the earlier stages of the disease, but in the latter ones, when there are signs of weakness of the heart muscle and the pulse is weak, it is indispensable. Other internal remedies are useless. Mercurialization—viz., calomel in small doses of three-quarters of a grain internally, and grey ointment externally—has no effect. The pain is scarcely ever severe, and if it is persistent it may be removed by cold and blood-letting. To this a high temperature is no drawback, as the fever subsides as the inflammatory appearances disappear. If effusion has begun, other means must be used—such as counter-irritation of the skin and the promotion

of reabsorption. Ice and blood-letting are of no use in this case. The cardiac region must be painted with equal parts of gall and iodine tincture, or an ordinary cantharides plaster may be applied, which should be kept on from eight to twelve hours till a blister is raised. This is of greater use in subacute pericarditis. Digitalis does not directly promote reabsorption, but indirectly by its influence on the action of the heart. Should the patient's life be threatened by copious effusion, paracentesis of the pericardium must be performed. This operation is often employed, and with not unfavorable results. Great care must be observed; the pointed trocar of Dieulafoy's apparatus must not be used, but a blunt one like that of Dr. Fraentzel.—*Lancet*, Sept. 4.

CLINICAL OBSERVATION REGARDING THE VALUE OF RESORCIN, ICTHYOL AND LANOLIN IN CUTANEOUS DISEASES.—Dr. H. W. Stelwagon, of Philadelphia read a paper on this subject before the American Dermatological Association.

Resorcin in eczema, is rarely of benefit, but possesses some power over the itching. For this purpose a 6 per cent. ointment is useful. In greater strength it is irritating. In tinea sycosis it has proven of some value in 10 to 20 per cent. strength. In tinea tonsurans, it is inferior to the remedies usually employed. In one case of leg ulcer, healing took place under its use. In a second case, no effect was produced. In seborrhœa and alopecia dependent upon this disease, a lotion consisting of a drachm of resorcin, one or two drachms of castor-oil, five minims of peruvian balsam, and four ounces of alcohol was of value. In tinea versicolor, it was found less useful than a solution of hypophosphites of sodium. In psoriasis and in one case of lupus erythematosus, the result was negative. In one case of superficial epithelioma, a 50 per cent. ointment produced a good result. In a second case, a fair result was obtained, and in a third the result was negative. In a case of favus, a 25 per cent. ointment used two months produced no decided effect.

*Ichthyol.* In a small proportion of

cases of rosacea and acne vulgaris a 10 to 20 per cent. preparation was found beneficial. In eczema it was valueless and usually irritating. In furunculus it acted with good results in three cases, when applied as a 20 per cent. plaster. In the fourth case it had no effect. It was of service in psoriasis and also in a case of lupus erythematosus. In favus, it was used without effect.

*Lanolin.* In some cases as an ointment base this is superior to the ordinary fats in use. Where a simple protective action is desired, it is inferior to vaseline, cold-cream or lard. In chronic cases, where there is infiltration and a degree of penetration is the object, lanolin is especially valuable. The writer stated that according to Liebreich, a *lanolinum purissimum* was now manufactured, in which the cholestrin ethers were absent. The main disadvantage of lanolin as now manufactured from sheep's wool, is its strong sheepy odor. In a few acute and sub-acute cases of eczema lanolin for some reason proved irritating. As a rule, however, it is bland and unirritating.

GELOSINE AS A VEHICLE FOR EXTERNAL MEDICATION.—Gelosine is a mucilaginous principle extracted from the *gelidium corneum*, a native of Japan. It is a colorless, amorphous, non-nitrogenous substance, which forms the basis of vegetable jellies. It is soluble in warm water, rendering solid on cooling five hundred and fifty times its own volume, the result being a fine transparent jelly, which is very slow to undergo putrefactive changes. M. Guérin considers that gelosine is admirably adapted for purposes such as poultices, vaginal and urethral suppositories, etc. The jelly undergoes gradual contraction, in which process any medicinal process contained is slowly expressed until complete dessication is effected, thus bringing it constantly into contact with the skin. The only preparation needed is to dissolve gelosine in suitable quantity in warm water, and then add the medicinal agent, either in solution or in a state of fine division.—*London Medical Record*, Aug. 16, 1886.



**HYDRONAPHTHOL.**—Dr. Justus Wolff asserts that E. Mercks' statement that betanaphthol and hydronaphthol are identical is a serious mistake, which may result in the most serious consequences if betanaphthol be used instead of hydronaphthol, "as the first one is most dangerous and deadly poison whilst the latter is an excellent absolutely harmless antiseptic." The poisonous character of betanaphthol has been established a long time ago by such authorities as Kaposi, Neisser and Piffard, and lately by Max Schwarz, while Dr. G. R. Fowler, Dr. Lawrence Wolff and many others, have proved hydronaphthol to be non-poisonous, and a most effective antiseptic. Hydronaphthol is distinguished from betanaphthol not only by its physiological action but also by distinct chemical reactions and by its chemical constitution, as it possesses certainly more hydrogen in the molecule than betanaphthol. Of the several distinguishing chemical reactions the following may be given as an example: If from a diluted iron-perchloride solution two drops are added to an alcoholic betanaphthol solution it becomes of a bright green color, whilst the same proportion of an alcoholic hydronaphthol solution of the same strength becomes dark yellowish brown by addition of the same proportion of iron perchloride solution. Other reactions are also different and the melting points obtained by most careful determinations are for hydronaphthol  $117^{\circ}$  C., and for betanaphthol  $122^{\circ}$  C. These and other facts satisfy the author that hydronaphthol is distinct from the poisonous compound which is known as betanaphthol and that it is not alphanaphthol nor a mixture of the two last named and does not contain any of either.—*Druggist's Circular*, for September.

**DEEP INJECTIONS OF YELLOW OXIDE OF MERCURY IN SYPHILIS.**—Dr. Shabek gives in the proceedings of the Kieff Medical Society an account of some observations made in Professor Stukovenkoff's clinic on the employment of yellow oxide of mercury injections in the condylomatous stage of syphilis. The solution used was prepared by rubbing

up sixteen grains of the oxide with twenty of gum arabic, and an ounce of water. The injections were made not hypodermically into the subcutaneous tissue, but, according to a plan recommended by Professor Smirnoff of Hel-singfors, the needle, which was four or five centimetres in length, being plunged almost vertically into the gluteal muscles. In three cases five injections were given; in one case, four; in one, six; and in one case, ten injections were administered at intervals generally of a fortnight, a grain of the yellow oxide being introduced each time by means of two separate punctures on opposite sides of the middle line. In some cases, however, half a grain was injected weekly. The writer found these injections well borne by patients, only very slight local signs of irritation being induced, and in many case none at all. In one case there was a hard swelling as large as a nut, but it was not painful, and soon passed away. The mercury, too, was always very quickly absorbed, being detected in the urine in four of the cases after the lapse of twenty-four hours from the first injection, and at the end of forty-eight hours in the other two cases. Dr. Shabek remarks that this method is inexpensive, simple, and efficacious, and will probably be found particularly useful in what in this country would be described as club, union, and dispensary practice.—*Lancet*.

**THE INFLUENCE OF MEDICINES ON DIGESTION.**—The rational method in therapeutics is founded on knowledge acquired largely from the experimental laboratory. Any careful investigation in the chemical department of physiology must ultimately prove of value, even though its present effect on practice may be slight or altogether lacking. O. Petersen, of St. Petersburg, has ascertained the influence of certain medicines on the duration of digestion. The inquiry was of the simplest order, as must necessarily be the case in exact experimentation. The problem Petersen set himself to solve was to ascertain the time required to digest twenty to forty grammes of dried albumen by the aid of 450 c.c. of an artificial gastric fluid made

of one gramme of pepsin to a litre of water and ten grammes of hydrochloric acid. Alcohol in the proportion of 5 per cent. did not hinder the digestion, but when the percentage rose to 10 digestion was stopped, whilst first being retarded proportionately before that percentage was reached. Antipyrin, in doses of two to two and a half grammes, exercised no influence on the rate of peptonisation, though larger quantities slightly retarded the action. One or two grammes of bromide or iodide of potassium hindered the process a little. The organic preparations of iron scarcely affected the time required for the digestion, whilst the reduced iron and the inorganic salts slowed the action. Magnesium and sodium sulphates, even in moderate doses, were in the same case. A gramme dose of chloral hydrate had no slowing effect, though marked retardation occurred with a dose of one gramme and a half. The chloride of sodium, as might have been expected, did not retard digestion, even when employed in large doses.—*Lancet*, Sept. 4, 1886.

END RESULT OF CARCINOMA OF THE LIP AFTER OPERATION.—A. Wörmer\* has collected and tabulated 866 cases from Brun, Thiersch, von Bergmann, Billroth, Winniwarter, Fischer, Kocher and Partsche. His results show that

782 cases (90.4 per cent)	were in men.
84 " (9.6 " " " "	women.
— " (94.4 " " " "	under lip.
— " (5.6 " " " "	upper "

The average mortality was 7 per cent., the minimum being 2.81 per cent.; the maximum 14.9 per cent., both of which results were obtained from data of the preantiseptic period. Permanent recovery occurred in 28.1 per cent., but among all cases of recurrence 87.6 per cent. occurred within one year after the operation, and cases which had escaped without recurrence for three years could, with great certainty, be considered cured. Wörmer mentions one case where a secondary operation was performed

nine years after the primary one, the patient surviving eleven years without recurrence.—*Boston Medical and Surgical Journal*.

PERFORATING INFLAMMATION OF THE VERMIFORM APPENDIX.—Writers are by no means agreed as to the exact relation of inflammation of the cæcum and of the appendix to peritonitis and perityphlitis. The vital importance of the timely and appropriate treatment of the disease in question is becoming more and more apparent. Such treatment is often postponed till hopeless, even if its application is at any time entertained. It was, therefore, to be anticipated that the critical consideration of a large number of unquestionable cases of perforation of the cæcal appendix might serve to make prominent the features essential for diagnosis and treatment. Such a study, based upon 257 cases of perforating appendicitis, has just been made by Dr. Reginald H. Fitz, and appears in the October number of *The American Journal of the Medical Sciences*.

From their consideration it is apparent that perforating appendicitis is a disease most frequently occurring among healthy youths and young adults, especially males. Further, that attacks of indigestion and acts of violence, particularly from lifting, jumping, and falling, are exciting causes in one-fifth of the cases. A local cause is to be found in more than three-fifths of all cases in the retention in the appendix of more or less inspissated feces, or in the presence there of a foreign body. The retention of feces may be promoted by a constipated habit, but congenital or acquired irregularities in the position and attachments of the appendix frequently act as favoring causes. A fact in support of the last-mentioned statement is to be found in the frequency of successive attacks, one or more, of inflammation of the appendix.

The inflammatory process once excited, its course and results show extreme variations; appendicitis may exist without giving rise to any characteristic symptoms, and often without a symptom of

\*Centralblatt für Chir., No. 25, 1886, s. 432.



any distinct malady. Errors in diagnosis have been numerous, chiefly because the cardinal symptoms of localized pain, general heat, and circumscribed swelling have not been duly appreciated in their defined sequence.

As to treatment, the first and last thought should be to keep the bowels quiet, together with absolute rest in bed, liquid diet in small quantities, often repeated, and, above all, sufficient opium to neutralize pain. If, after the first twenty-four hours from the onset of the severe pain, the peritonitis is evidently spreading, and the condition of the patient is grave, the question should be entertained of an immediate operation for exposing the appendix and determining its condition with reference to its removal. If any good results are to arise from such treatment it must be applied early. If surgical interference is not instituted within the first twenty-four hours after the onset of the sudden and intense right iliac pain, to keep the bowels quiet must still be the injunction. The formation of the tumor, the circumscribing of the peritonitis, is then to be awaited. It is sure to form, in the large majority of cases, if the patient lives long enough. It is only in a small fraction that it occurs before the third day. In more than two-thirds of the cases the contents will escape externally or internally. Without surgical aid the escape is into the peritoneal cavity in most instances, with a rapidly fatal result. In a smaller number the escape elsewhere not infrequently produces serious if not fatal sequels.

Dr. Fitz concludes his elaborate study of the disease and its treatment with the following statements: The vital importance of the early recognition of perforating appendicitis is unmistakable. Its diagnosis, in most cases, is comparatively easy. Its eventual treatment by laparotomy is generally indispensable. Urgent symptoms demand immediate exposure of the perforated appendix, after recovery from the shock, and its treatment according to surgical principles. If delay seems warranted, the resulting abscess, as a rule intraperitoneal, should be incised as soon as it

becomes evident. This is usually on the third day after the appearance of the first characteristic symptom of the disease.

THE POPULATION OF FRANCE.—M. Bertillon, in the course of a lecture recently delivered at the Hygienic Exhibition in Paris, stated that out of every 1000 inhabitants of Paris only 360 are natives of the city, 565 belonging to the departments of France or the colonies, and 75 being foreigners. There are in proportion as well as in actual numbers more foreigners in Paris than in most other large cities, the proportion being 75 in 1000, as against 14 per 1000 in Berlin and Trieste. The movement of the population for the past year throughout France was also very unsatisfactory, the total number of births being 922,361, or upon the average 30,000 fewer than for the last fifteen years. Moreover, out of this total, 74,118 were illegitimate, or rather more than 8 per cent. of the whole, this being the largest number of illegitimate births ever recorded. Upon the other hand, there has been a slight reduction in the number of deaths, the total for 1885 being 836,897; but even so, it will be observed that the excess of births over deaths was only 85,464.—*Lancet*.

LEMONADE IRON.—The following method of prescribing the muriated tincture of iron, is recommended as being the most palatable, elegant and altogether satisfactory method ever yet offered to the profession. Professor Goodell, of Philadelphia, terms it "lemonade iron." I think it originated with him:

R	Mur. tinct. ferri.	3 iv.
	Acidi phos. dil.	3 vj.
	Spts. limonis	3 ij.
	Syr. simp. ad.	3 vj.

M. Sig.—Two teaspoonfuls in water after each meal. The spirits of lemon is preferred to the syrup of lemon, as the latter would render the mixture too acid. I have found the above combined with pepsin, an excellent tonic when indications are associated with feeble digestive powers.—*Med. World*.

**ANTISEPTIC PAPER DRESSING.**—Dr. Don Antonio Morales Perez describes in the *Revista Médica* of Seville a simplified antiseptic or Listerian dressing, consisting of bibulous paper heated to 110° C. and soaked in a solution of carbolic acid, boracic acid, or corrosive sublimate. This is placed over the wound in about eight layers, and covered with sheet gutta-percha or mackintosh, the whole being secured by an india-rubber bandage. The writer claims for this dressing the advantages of cheapness and portability, and thinks it will be found very serviceable in the field and in small hospitals.—*Lancet*, August 21, 1886.

### Medical Items.

Professor Von Arlt, of Vienna, is reported to be seriously ill with grangrene of the leg.

Kansas City seems to be a Mecca for physicians. It is stated that nearly fifty have located there within the past two months.

The *Lancet* announces the death of Mr. Sampson Gamgee the well-known English surgeon, author and lecturer.

Lectures at the different Medical Colleges in this city were resumed during the present week. We learn that the number of students matriculating at the several schools is larger than usual. The indications are that very large classes of medical students will spend the winter here.

The citizens of Baltimore are just now being presented with the circular of a "Pile" Doctor of this city, which announces his successful treatment of Piles, Fistula, Fissure, etc., and offers as "Home evidences of success" the names of a large number of our people. It must be exceedingly flattering to the vanity of these well-known citizens to have their infirmities paraded so conspicuously in a hand bill. There is nothing so refreshing to the pride of the average man as notoriety, even though this notoriety affixes its stamp upon the lower outlet of his digestive apparatus.

A number of influential citizens residing in the Eighth ward have requested Dr. J. Brooke Boyle, of this city, to become a candidate for the First Branch of the City Council, subject to the decision of the Democratic primary election. Dr. Boyle has consented to become a candidate at the primary election soon to be held. The doctor is eminently qualified to discharge the duties of the position to which his political friends desire to elevate him. In his own behalf and in behalf of the medical profession of our city, we wish him success in the coming election. We need just such men of integrity and intelligence in the city council chambers.

At the meeting of the Clinical Society of Maryland, held October 1st, the following officers were elected to serve for the ensuing year: President, Dr. Randolph Winslow; Vice-President, Dr. S. T. Earle; Recording Secretary, Dr. A. C. Abbott; Corresponding Secretary, Dr. W. J. Jones; Treasurer, Dr. R. W. Johnston; Executive Committee, Drs. J. W. Chambers, H. Harlan and B. B. Browne. The reports of officers and committees show a very healthy condition of the Society, the treasury having an ample surplus for current expenses and the membership of the Society having increased to 190 active members. The Society meets on the first and third Fridays of each month at 8 30 P. M., in the hall of the Medical and Chirurgical Faculty of Maryland, N. W. corner of St. Paul and Saratoga Streets.

Professor Bull, of Paris, states that there are two ways by which the morphine habitué can be detected, and these are to be found in the skin and in the urine. The skin will be found to be covered with little dark spots situated in the centre of little indurations about the size of a large shot. It is needless to add that these indurations are the result of the little wound of the needle, but as these lesions are generally found on the inside of the thighs, the patient refuses to let them be seen, and in that case examination of the urine will prove of great service. A few drops of tincture of iron are put into the suspected liquid, and if morphia be present a blue tinge will be produced.—*Medical Record*.

The administration of very small and frequently repeated doses of calomel, is recommended by Dr. Musser, of Philadelphia (*The. Gazette*), in the treatment of summer diarrhoea and vomiting of infancy. In severe cases he recommends a powder containing one-eighth to one-twentieth of a grain of calomel, combined with one-twelfth to one-fourth of a grain of Dover's powder, if there be much pain, fever, or restlessness. The ingredients, combined with a small quantity of powdered sugar, make a very minute powder, which is placed dry on the tongue, and washed down by a spoonful of water, with or without stimulant. He recommends that the dose should be repeated every half-hour at first.—*Boston Med. and Surg. Journal*.

The *Baltimore Sun*, of October 7th, publishes a statement of the financial resources of the Johns Hopkins University. For the year ending August 31st, 1886, the income was \$225,922.38. The total expenses for the year were \$185,020.96; leaving a balance of 40,901.42. Among the receipts \$17,804.12 were credited to tuition. Among the expenses \$126,828.26 are charged to salaries. The University owns 15,057 shares of B. & O., Railroad stocks valued at \$2,195,400. The remainder of its endowment fund is invested in bonds, stocks mortgages, real estate, buildings, apparatus, etc. The total endowment is \$4,359,350.43. In addition, the University owns the Clifton estate of 280 acres which is valued at \$2,000 per acre, making the property of the University worth to-day about \$5,000,000.



## Original Articles.

### A SHORT NOTE ON TWO CASES OF TRAUMATIC ANEURISM CAUSED BY PRESSURE.

BY OSCAR J. COSKERY, M.D.,

Professor of Surgery, College of Physicians and Surgeons, Baltimore.

Master William R., aged 18, on June 19th, 1886, while using a half-inch chisel had it to slip and deeply penetrate the hypothenar region of his right hand. The flow of blood was profuse, but he had sufficient presence of mind to press firmly upon the wound, and thus stop the hæmorrhage. Five minutes after the injury I saw him. A pad was applied tightly over the wound for forty-eight hours. Pressure was then eased, but the pad of lint was left on for one week, when it was found to be loose, and the wound entirely healed. Nothing particular referable to the wound was noticed by the patient until July 16th, when, while digging with a spade he observed a throbbing in his hand. He was then in the country, but came to see me the next day, July 17th. There was then a pulsating tumor, three-quarters of an inch in every direction, beneath the scar. The character of the pulsation left no doubt as to its being a traumatic aneurism. A piece of lead pipe, one-quarter of an inch in thickness, and of a sufficient diameter to enclose the swelling, was applied over a thin pad of dry lint, and the requisite amount of pressure to arrest pulsation was gotten by a piece of isinglass-plaster passed spirally over the leadpipe. This was not touched until it became loose, which was in about a week, and then a decided amount of consolidation was recognized. The treatment was continued for two weeks longer with steady improvement, and then the pipe was discontinued, and a simple pad of lint was used under the plaster. By September 15th, the tumor had almost disappeared, but at one point a rather large vessel could be felt pulsating freely. On Oct. 1st, A. M., pressure was removed. There is at present a small

dimpled scar to show the site of the aneurismal swelling.

Frank W., aged 23, a bristle worker, on June 12th, 1886, while opening a clam-shell, had the knife to slip, and the point entered his left hypothenar region. The bleeding was profuse. His account was that he lost "two quarts" before he found a physician. The history was that a pad and pressure were employed; that the pad was removed in three weeks; that he went to his work in the fourth week, or about one week before he came to me, not for the aneurism, but for hyperidrosis of the hands from which he had suffered for months before meeting with the accident. This profuse sweating had increased since a swelling had made its appearance around and beneath the scar. On examination, I found a freely pulsating tumor, measuring an inch and a half in every direction. The same plan of treatment, with a larger piece of lead-pipe, etc., was adopted as in the first case, but very little came of it. The patient was then taken into hospital for operation. Before doing the bloody operation I thought I would make one more effort with pressure. By careful watching, and not letting the pad get loose, in one week decided improvement had taken place. This improvement was continued, and, at the present time, where we have a sac nearly as large as a pullet's egg, into which blood was freely pumped, and which was steadily enlarging, we now have only a hard mass of coagulated blood, about the size of a filbert, and which undoubtedly will undergo organization.

For a time, under bromide of potassium, the hyperidrosis seemed to improve, but now is nearly as bad as ever.

## Society Reports.

### CHICAGO GYNÆCOLOGICAL SOCIETY.

REGULAR MEETING HELD AUG. 20, 1886.

The Vice-President, HENRY T. BYFORD, M.D., in the chair.

*Dr. W. W. Jaggard* exhibited

AN OVUM CORRESPONDING TO THE FOURTEENTH WEEK OF PREGNANCY, SHOWING TWIN PREGNANCY, WITH ONE PLACENTA, ONE CHORION, ONE AMNION, BOTH EMBRYOS OF THE MALE SEX.

The interesting specimen was placed at his disposal through the courtesy of Dr. Daniel H. Williams, of Chicago. The egg corresponded to the fourteenth week of pregnancy. It was a case of twin pregnancy, with one placenta, one chorion and one amnion. The embryos were equally well developed and were of the male sex.

The case illustrated one of the modes of origin of multiple pregnancy. An ovum may have two nuclei, and an embryo may be produced from each nucleus. Under these conditions, the fecundated ovum has one placenta (or there is anastomotic communication between two fused placenta), one chorion and two amnions. The amniotic septum may be broken down or absorbed, and the embryos may be contained in a single amniotic sac, as in the specimen exhibited.

In a case of single placenta, or fused placenta with anastomotic communication, and a single chorion, the twins are always of the same sex (Hyrtl, Spaeth, Braun).

*Dr. John Bartlett* read a paper entitled

#### A PROPOSED MODIFICATION OF PORRO'S OPERATION.

After giving a concise history of the classical and Porro's operations, Dr. Bartlett said:

"The substitute for Porro's operation which I have to propose is as follows: The operation proceeds as in Cæsarean section till the child is removed, the actual cautery being used in opening into the womb. Then, instead of dragging the womb out of the abdomen through the abdominal incision, it is dragged out of that cavity through the vagina. The operator passes a Well's clamp, somewhat modified in its prehensile surfaces and properly curved in coincidence with the parturient canal, to the fundus of

the uterus and there secures a firm grasp into the uterine tissues. By traction upon these forceps, and pressure, and suitable manipulation from above, the fundus of the uterus is depressed into the body of the organ, dragged through the cervix into the vagina to produce complete inversion. The clamping wire is immediately adjusted, and excision of the uterus and appendages effected at a suitable distance from the vaginal junction. The abdominal wound is closed, and attention is given to the stump with reference to hæmorrhage as in Porro's operation. In lieu of the clamping forceps, in some cases it would answer better, doubtless, to pass a loop of copper wire through the walls of the uterus to be caught upon a suitable instrument, as a rod possessing the flexibility of block tin or solder, passed *per vias naturales* to receive it. The advantages of this operation over Porro's method which suggest themselves are: *First*, that the abdominal cavity is thoroughly closed; the abdominal incision, not being embarrassed by the presence of the large pedicle is as perfectly and as quickly closed as in any other laparotomy. By the process of inversion the pedicle is placed outside of the abdominal cavity, while what may be termed the uterine inlet made into the peritoneal sac is closed by the clamping wire opposing serous surface to serous surface, thus offering the best prospect for speedy and certain agglutination and closure. *Second*, the relation of the parts in the suggested procedure is much more natural, and much less strained than in the *status* in which Porro's method leaves them. *Third*, in the event of drainage becoming necessary in the course of treatment, the effecting of an opening for a tube in the plan proposed can be accomplished very much more easily and safely than in Porro's plan and the tube being introduced, its situation and direction would be the best possible for thorough cleansing of the cavity to be washed.

Serious objections at first thought will occur to the mind of every gynecologist. These will be here stated and subsequently met, as well as may be, by



considerations that may be urged in answer to them.

*First.*—Of all the accidents *post-partum* none is generally accredited with so violent a shock to the patient as the very condition which is here made a main feature in a method proposed as conservative. In the old, and in Porro's operation it almost always happens that, either with or without the partial or complete separation of the placenta the uterus contracts. With such a condition of the uterine walls inversion would prove difficult and sometimes probably impracticable. Hunter said a contracted uterus was as difficult to invert as a jack boot. When to these difficulties incident to the first step of the operation are added the shock from clamping and incising the uterus, it would seem that the dangers incident to the method proposed might exceed those of the Porro operation.

*Second.*—In Porro's operation, as in the Cæsarean section, danger begins from hæmorrhage at the moment of incising the uterus, and in the method proposed this danger would be so much the greater as the time elapsing between the two events, incision and snaring of the pedicle, is longer. In the established operations in at least one-sixth of the cases the placenta has been encountered directly in the line of incision. In such instances the bleeding from the double wounds, uterine and placental, would, in an especial manner, embarrass the operator and endanger the patient.

*Third.*—It must be remembered that in the great majority of cases in which the operations under consideration are undertaken there exist contractions of the pelvis, which may seriously interfere with the main step of the operation, inversion of the uterus.

*Fourth.*—Apart from these more serious objections it may be urged against the plan by inversion that dilatation of the *os uteri*, a *sine qua non* of the method proposed, does not always exist at the time of operation, and that it may not always, or even often, be practicable safely to effect it.

These objections will now be considered seriatim. As to the first, regarding the shock to the system so often reported

in association with inversions, it may be stated that associated with inversions, also is very generally hæmorrhage, and to this all-powerful cause of depression may be ascribed much of the shock noticed in cases of inversion. While it must be admitted that in some instances inversion alone, entirely unassociated with bleeding, seems to have produced great shock, and even death, it may yet have happened that in some of these cases, other injuries, as laceration of the uterus, accompanying the inversion, may have been partly responsible for the profound impression observed, and one is the more justified in assuming that this objection may be over estimated, from the fact that in a number of cases carefully observed and reported, inversion has produced no shock whatever, and has in fact been accomplished without the knowledge of either patient or obstetrician.

Blundell, Dailliez, Dugé, Crosse, Lee, were quoted to support the proposition that shock *per se* is not the cause of alarming symptoms or death in inversion of the uterus.

By reference to veterinary surgery, cases may be adduced to show not only that uterine inversion among animals is not *per se* especially dangerous, but that inversion, complicated with accidents in themselves accounted most dangerous, is not necessarily fatal. In such cases reposition alone, unaccompanied with any care for existing uterine lacerations may be followed by perfect and speedy recovery. In support of this proposition cases were cited from the writings of J. Rainard, Guilamin, Gellé, Elevout.

As to the objection regarding the difficulty of inverting the uterus after contraction, it must be admitted that contraction of the uterus into a firm body would certainly render more difficult the inversion. The facility with which the flaccid uterus may fall into itself like tripe, or a wet bladder or the finger of a glove, certainly contrasts strongly with the difficulties encountered by experts in restoring the inverted uterus, even as early as four hours after labor. In the absence of any experience in the matter of purposely inverting the uterus, it will be

necessary in support of the practicability of this feature of the proposed operation to draw upon experience derived from practice in midwifery. A variety of facts may be brought to bear to show the likelihood of success in efforts at inversion which may be in a measure classified thus: direct facts as to the ease with which it has been accomplished directly after labor; facts showing the readiness with which from trifling causes inversion may be induced within a few weeks after labor; facts seeming to show that it may even occur in the virgin uterus, and apparently from minor causes. Replacement of the uterus after inversion, whether that organ be lax, moderately condensed, or in a state of complete involution, is an act so nearly akin to that of inversion that any facts tending to indicate the facility with which an inverted uterus may be restored to position have a bearing upon the question of the practicability of inverting the uterine tissue. Hence in the category of available facts for our present purpose belong those showing facility or possibility of reduction of the inverted womb at any stage or condition of inversion. Referring to inversion, Barnes, Hunter, Byford, Gooch, Boivin, Dugé, Baudelocque, Radford, Cowan, J. Y. Simpson were quoted to prove (1) the ease with which inversion has been accomplished directly after labor, (2) the readiness with which from trifling causes, inversion may be induced within a few weeks after labor, (3) that inversion of the uterus may even occur in the virgin uterus. Facts were adduced to prove the ease with which even the chronic inverted uterus was restored. Fraenkel's experiments with atropia, morphine, and chloroform in cases of spastic contraction of the uterus in the second or third stages of labor were suggestive.

This combination recommended by Dr. Fraenkel, injected into the *cervix uteri* at the proper moment before the operation, might be relied upon to antagonize any excess of contraction of the uterus which experience might show to interfere with the efforts of the operator to invert the uterus.

In regard to the objections having re-

ference to hæmorrhage from the uterine incision, it will be observed that in the plan proposed, the incision through the uterine walls is made with the cautery. While it is probable that the protecting power of this agent would guarantee the arrest of the bleeding from the uterine wound for a time under conditions of rest, it must be admitted that, in subjecting these seared edges to the changes of relation incident to the process of inversion, there would be danger of reopening the vessels and loss of blood. In such a case the assistant managing the thermo-cautery would follow the edges of the wound with the purpose of re-touching the bleeding points when practicable. That the actual cautery will arrest the hæmorrhage from the uterine wound, even under circumstances of change in its size, etc., the following facts prove.

R. W. Felkin, Breitmann, Playfair, Baudelocque, Edmunds, James Whitehead, Robert P. Harris, Fancourt Barnes were cited in support of the proposition that hæmorrhage is rarely the cause of death.

In regard to the third objection having reference to the narrowing of the pelvis, and the difficulties in the way of the suggested procedure thereby presented, it may be stated that while narrowing of the pelvis would always prove more or less hindrance, yet it must be borne in mind that in the majority of cases of deformed pelvis, however much any given diameter may be shortened, there yet remains spaces to one or the other side of the narrowing line through which the womb might be made to pass by the *vires a fronte et a tergo*. Generally in the process of inversion, as the uterus would be drawn through the superior strait, four thicknesses of the organ would be presented at the conjugate; and in cases of unusual narrowing, difficulty might be experienced in this manœuvre. In extreme contraction of the pelvis, dexterity and ingenuity on the part of the operator might enable him to cause the organ to pass in the process of inversion a very narrow space, possibly not wider than twice the thickness of the uterine parietes. Thus by



making the incision, where practicable, near the fundus the fold formed by one lip of the wound and its apposed surface of uterine wall might be made to pass; to be followed by a similar fold of the corresponding edges of the incision.

Stein and Wiegand recommend that after the operation of Cæsarean section if the uterus does not contract so as to sink into the pelvis, it shall be seized by the whole hand, as in taxis for hernia, and be pressed down into the pelvis. In a narrow brim, this procedure they think, insures that the uterus once pressed into the pelvic cavity cannot rise out of it again. Spitzbarth makes a similar suggestion. These recommendations of practical men suggest the feasibility of inverting the uterus by adroit manipulation even in cases of marked contraction. It may as well be stated, however, that the plan of operation here proposed has its limits of practicability as compared with the Porro operation, cases of extreme pelvic obstruction as well as those involving such changes in the parenchyma of the uterus as would render inversion dangerous, if not impracticable would, of course, not fall in the category of those to which the method here suggested might be applicable.

In regard to the fourth objection as to the hindrance presented by a non-dilated *os uteri*; it may be said that according to the majority of authorities, the most favorable time for performing Cæsarean section is after labor has set in, and should interference be delayed till the *os uteri* were softened and ripe for dilation in the greater number of cases the delay would not prove injurious to the mother or child.

With the present means of dilating the cervix during labor, it is to be presumed that while an imperfectly dilated *os* would not unfrequently prove a hindrance it would not often be an abstacle in the way of the proposed operation.

Barnes, Thomas and Lusk were cited to prove the ease with which the *cervix uteri* might be dilated.

It may be inquired, what would be the relation of the ovaries to the proposed line of ligature in an inverted womb? Several writers refer to the

ovaries as resting on the edge of the inverted uterus as if about to fall into the cavity. A specimen from which this statement has been deduced forms the original of one of the standard cuts representing that condition. It is a case of partial, not of complete inversion. Some authors, as Boivin and Dugé, state that the ovaries are not within the cavity of the uterus. Other writers, as Levret, report cases in which the ovaries were found within the inverted cavity. Schultze states that they are there found, and the cut that accompanies his text so shows these organs. In a number of instances, recent and old, the amputated uterus has been found to contain one or both ovaries. In many cases of chronic inversion the appendages have not been found within the cavity of inversion. A study of the relation of the ovaries after complete inversion of the uterus will lead to an indorsement of the statements of Winckel and Schroeder as correct. Winckel writes, "In puerperal inversion, as a rule, the tubes and ovaries fall into the cavity (of inversion)."

Says Schroeder, "In recent puerperal inversion all of the appendages are in the uterine funnel."

In the records of medicine are not wanting quite a number of cases the history of which teaches that the plan of operation here proposed may not be fatal. Cases were cited from the work of Denucé on "Uterine Inversion" to prove the latter proposition.

In conclusion Dr. Bartlett said: Mr. President: In the course of my researches in preparing this paper, I have looked expectingly for the presentation of the same proposition as I have here made from co-laborers in the field of obstetric surgery. I have been rather surprised to have met no allusion to the method. The germ of the plan here proposed may however be found in the writings of that brilliant obstetrician to whom more than any other, suggestions for improvement in the operation of Cæsarean section are to be credited, James Blundell. In his article on laceration of the uterus, occur these words: "Would extirpation of the uterus *with or without inversion*, be of service in these

cases? This question may be answered next century.\*

#### DISCUSSION.

Dr. A. Reeves Jackson said: I have never performed Porro's operation and am not sufficiently familiar with the literature of the subject to be a proper person to open, or even take part in the discussion. I confess I scarcely understand what advantages this operation proposed by the essayist offers over the improved operation by Säger. I would like to know whether Dr. Bartlett has performed this operation either upon the living subject or on the cadaver. It seems to me there are practical difficulties in the way. In a review by Harris, of Philadelphia, in the *American Journal of Medical Sciences*, of the work of Mangiagalli, "On the More Recent Modifications of the Cæsarean Section," it is stated that it had been proposed to invert the uterus; for the purpose, however, of lessening the danger from septic infection, and not to facilitate the amputation, as is designed by the suggestion of Dr. Bartlett.

Dr. E. J. Doering asked how often the Cæsarean operation had been performed in Chicago.

Dr. W. W. Jaggard thought Dr. Bartlett's paper a very ingenious essay, although not based upon sound surgical principles. In the first place, he thought the title of the essay a misnomer. The operative procedure proposed by Dr. Bartlett was not in any sense of the term a modification of or a substitute for Porro's operation. It was a perfectly distinct operation. Dr. Bartlett's method offered no advantages over Porro's operation, as modified by Müller and others. The

abdominal cavity is not more thoroughly closed. The presence of a large pedicle does not embarrass the closure of the abdominal incision. The relation of the parts in the suggested procedure are not more natural and much less strained than in the *status* in which Porro's method leaves them. Drainage is entirely unnecessary when Porro's operation has been skilfully performed.

On the other hand, the positive disadvantages are numerous: The dangers of shock and hæmorrhage in artificial inversion of the uterus have been very much underestimated by Dr. Bartlett. The cases collected from the literature of the subject, when they were at all relevant, were questionable as to authenticity. Accidents occurring to the uterus among the lower animals could not be adduced in evidence as to what would be the probable effect upon human beings under similar conditions. The thermo-cantery was inadequate to the arrest of hæmorrhage from a large incision through the walls of the pregnant uterus.

The uterus could only be inverted with ease, when it was pathologically flaccid—an exceptional condition. Porro's operation was performed in cases of the simple, flat rachitic pelvis, when the antero-posterior diameter of the brim was 6 cm. or under. Above 6 cm. craniotomy or the forceps is indicated. It would be very difficult to invert the uterus through the conjugate, oblique or transverse diameter under such conditions. In the pelvis of Robert, or in the osteomalacic pelvis, in which the degree of contraction is usually higher, artificial inversion of the uterus would be wellnigh impossible.

Then amputation of the inverted uterus is a dangerous operation *per se*. Of the forty-eight cases collected by Dr. West,\* twelve terminated fatally. Of fifty-eight cases of amputation of the uterus, reported from a German source,† eighteen terminated fatally. "In‡ 106 cases of amputation by ligature and

\*After writing this article the writer found in the essay of Dr. Harris on the Porro operation in continental Europe, published in the *American Journal of Medical Sciences*, in 1880, the following sentences:

"Several other plans [of treating the cervix] have been proposed. \* \* \* (2) to invert the uterus after its evacuation and constrict and remove it by the vagina. This plan tends to complicate the case and increase its dangers, etc."

Had the writer been aware that the suggestion which forms the basis of the foregoing paper had been previously published he would not have prepared it. Inasmuch, however, as the merits of the method proposed are in no wise affected by its having been previously suggested, he has decided not to withhold the article from publication.

\*Diseases of Women, p. 240.

†American Journal of Obstetrics, Aug., 1868.

‡Emmet: Principles and Practice of Gynecology, 1884, p. 430.



otherwise, over 31 per cent. of deaths occurred." But it is not necessary to multiply statistics. So great is the mortality of this operation, that A. Martin\* has proposed as a substitute the total extirpation of the uterus.

If, then, upon *à priori* grounds, Dr. Bartlett's suggestion has no real advantages over the modified Porro operation, and, on the other hand, possesses actual disadvantages, it is scarcely probable that the expedient will receive serious consideration.

Dr. J. Suydam Know said: Dr. Jagard has about covered the objections I intended to make: My impression is that Dr. Bartlett in his paper has overestimated the relaxation of the uterus immediately after delivery, and the ease with which inversion can be accomplished. Atony of the uterus is the first cause of inversion; and when we consider how minute is the percentage of inversions in the vast number of labors, we can fairly assume that relaxation immediately after delivery seldom occurs. If this be so, inversion, even with the *vis a tergo*, would be extremely difficult. Again atony of the uterus is the cause of the most dangerous symptom or complication of inversion, namely hæmorrhage; therefore the cases most favorable for the operation of Dr. Bartlett would be the last ones in which so doubtful an experiment can be tried. The Doctor has made a valuable suggestion. Any method that successfully removes the uterine stump from the abdominal cavity, without attaching it to the abdominal incision, advances the operation of hysterectomy. In the ablation of the non-pregnant uterus, I think Dr. Bartlett's method finds its best application.

Dr. James H. Etheridge asked if the performance of inversion by forcible traction involved the full dilatation of the neck of the uterus. How does Dr. Bartlett propose to accomplish this, does he dilate it forcibly? With the uterus well up beyond the umbilicus, how do the broad ligaments come out of the pelvis, and with the uterus forced clear down out of the vulva, how much trac-

tion is there going to be on these broad ligaments? Is there room enough to permit the uterus to be drawn down?

Why, under the circumstances, could not forceps be immediately applied to the edge of the cut uterus, and arrest the hæmorrhage, and the work be then proceeded with at pleasure? I speak of hæmostatic forceps.

Dr. E. W. Sawyer said: It seems a little presumptuous for one who has never had experience in this department to attempt to enlighten the Society. One of the most interesting questions to be decided is which operation to perform. I confess if I were confronted to-night with one of these cases I would be wholly incompetent to decide between Cæsarean operation and the operation of Porro. It may be interesting to read the words of Lawson Tait upon this very point, showing his preference for the new operation, so-called. In the fifth number of the *British Gynecological Journal*, he says: "The whole of my experience in meddling with the pregnant uterus by abdominal section, consists of five cases, three of the ordinary Cæsarean section and the two I am about to describe in detail. Of the Cæsarean sections one was performed for malignant disease of the vagina about fourteen years ago, the other two for deformed pelvis respectively seven and five years ago and the mothers died, and only one of the children is now living. The results indeed are such as to determine me never to repeat this procedure, having before me the arguments of Dr. Godson and the fact that both my amputation cases have recovered." At the same meeting Dr. Routh said: "That he was much interested and instructed by Dr. Lawson Tait's paper. At the same time he could not help making some criticisms upon it. First, he believed that Mr. Tait had exaggerated the mortality of the Cæsarean section. It was not anything like 99.971 per cent. Churchill stated that out of eighty cases twenty-three mothers were saved, or 28.7 per cent, forty-four children being saved. Dr. Radford out of seventy-six cases he collected, found 14.28 were saved, and forty-six children

\*Pathologie und Therapie der Frauenkrankheiten, 1885, p. 141.

were also saved. Dr. West, out of 409 cases states the recoveries as 38.4 per cent. 237 children being saved. Now he (Dr. Routh) could not help feeling that if in these days of improved antiseptic abdominal surgery, the same skill and care were taken in cases of Cæsarean section, the safety of the mother would be much more common." It is interesting to see how gentlemen will differ in their opinions upon such an important thing as the selection of an operation in an emergency case. So I am still in doubt whether to adopt the modern method of Porro or to depend upon the Cæsarean section, which the remarks of Dr. Routh would indicate is quite as favorable.

At the request of Dr. Etheridge, Dr. Sawyer narrated the following case, showing the shock and hæmorrhage of acute inversion: I will state very briefly an experience which, no matter how long I may live, seems as if it would never become dim. I never had any doubt that the determining cause of the acute inversion in this case was the enormous distension of the uterus due to the large quantity of *liquor amnii*. Before the woman was delivered, I was impressed with the fact that she probably had twins, but this was not the case. When the woman was delivered the bed was flooded, the *liquor amnii* flooding the room even. I put my hand upon the woman's belly, as is my custom, and at the first indication of contraction of the uterus, I substituted the husband's hand for mine that I might pay attention to the child. I am confident that the husband's fingers dimpled that uterus. I had no sooner detached the child than I gave the usual teaspoonful of ergot; I was in a hurry on account of the flabby condition of the uterus, and for fifteen minutes my time was occupied in paying attention to the child, getting it to breathe. The woman, who had recovered from a small quantity of ether which I gave her, threw up her hands and I saw she was pale. I put my hand under her husband's and felt the edge of the uterus like the edge of a saucer. I could define the margin of the crater; my finger in the vagina met the globe inverted, and the truth flashed across

me that I had an inverted uterus. Now fifteen minutes had not elapsed before that uterus was so firmly ergotized that it was impossible to replace it. I immediately resumed ether and the woman began to snore, but that made no difference, the womb was ergotized and the woman died from shock and hæmorrhage with the uterus unreduced.

Dr. Jaggard has called attention to the enormous hæmorrhage, and this reminds me of a case in which I removed a foetus from the abdomen of a woman, in the little town of Boulder. The foetus had been in the uterus for three and a half years. It was an adventitious uterus, the exact structure of which could not be ascertained, but the hæmorrhage from the false uterus was enormous and I think destroyed the woman. If the false uterus and adventitious sac could bleed to that degree and so early in pregnancy, the dangers of hæmorrhage must surely be greater in the uterus at term containing a living foetus and an active placenta.

This operation was done in 1874. The hæmorrhage was cavernous. We arrested the hæmorrhage by seizing the edges and puckering them up and tying an enormous ligature around the stump; for a moment that arrested it, but the woman subsequently died.

Dr. H. T. Byford said: Like any other operation this one, supposing it to be an operation that has been performed, has its limitations. I think Dr. Jaggard's suggestion that a greatly contracted pelvis might afford sufficient difficulty to make the operation impracticable, is a good one, although I think that the uterus might be inverted through a pelvis too small or too much distorted for a safe craniotomy. Another limitation would be an undilated condition of the cervix. The irritation produced by rapid dilatation would certainly render the cervix unfit to be left as a stump, and make the Cæsarean or Porro operation preferable. If the os is already dilated, then Thomas' revised laparo-elytrorrhaphy must be given precedence, provided there be no contradictions. The difficulty of inverting the uterus is not an imaginary one, and it seems to me



that the best way to overcome it it would be to invert the uterus, placenta and all, before the placenta is separated, and between pains. This would tend to still further limit the operation to cases without extreme contraction and would bring it into rivalry with craniotomy. Its chief advantage over the Porro operation lies in not fixing the cervix several inches beyond its normal position; and here lies the germ which the author seems to be trying to develop. Should there be a condition of the uterus which would not favor the Cæsarean operation as performed by Säger and Leopold, should the size of the cervix or vagina render fixation of the stump in the abdomen too difficult, were the the uterine walls not sufficiently relaxed to be inverted, or the pelvis not roomy enough to allow inversion with the placenta attached, should the condition of the tissues about the vagina and bladder contra-indicate laparo-elytrorrhaphy, and should the os dilate naturally and easily, then this operation would find its rare opportunity. The process of coning out, or rather slicing around the cervix, and inverting the cervix, is easier to talk of than to perform. Any one who has seen the uterus amputated, even in cases of fibroid tumors, will agree that the loss of blood, including that taken off with the amputated pregnant uterus, and the vascularity of the stump would make the process of inverting the sliced cervix very hazardous. The stump, thus turned down, would undoubtedly shrink rapidly, and become a hard one to manage. As to opening the uterus with the cautery, I think that this would not possess much advantage unless complete constriction of the uterus and broad ligaments could be made, so that bleeding would not interfere with the complete searing of the parts.

*Dr. Bartlett*, in closing said: Some of the Fellows taking part in the discussion, as they have stated, have not had an opportunity of hearing more of the paper than the bare proposition; not needlessly to occupy time, I shall pass over such objections (all of which I recognize as forcible), as have been fully considered in the paper now printed.

Dr. Jaggard refers to the authorities quoted by me as "questionable;" so far as my knowledge extends, not a case cited rests upon other than unquestionable authority. The Doctor thinks the actual cautery would prove useless as a means of arresting hæmorrhage from the uterine incision. Prior to the time of Ambrose Paré, the cautery was relied upon "to arrest all forms of hæmorrhage."

Dr. H. T. Byford has dwelt upon the difficulty of dilating the *os uteri* by artificial means, and in my opinion he has not exaggerated the difficulties often encountered in practice, where the parts are not prepared for dilation.

In regard to the embarrassment felt by the Secretary as to which operation to prefer, whether the old or the Porro method, I might say, that, in face of the several substitutes and modifications, he would be amply justified in preferring the old Cæsarean section.

### Correspondence.

#### SOME OBSERVATIONS IN SYRIA.

BALTIMORE, September 30, 1886.

*Editor of the Maryland Med. Jour.*

DEAR SIR:—Some days ago I had the pleasure of spending a few hours with Dr. T. W. Kay, who has been at Syria for three years, as a professor in the Protestant Syrian College at Beirut. The doctor graduated at the College of Physicians and Surgeons, of this city, some years ago taking first prize and the Cathell gold medal.

After enjoying a lucrative and extensive practice in a Pennsylvania City, he sacrificed personal good and pleasure in order to benefit his fellow men who have very few of the advantages of the advanced civilization found in England and America.

The doctor reports himself well satisfied, and will return to his work about October 1st. His mission here is one of a purely social character—the visiting of relatives and friends—and he has declined all invitations to lecture, which

have been showered upon him. It is much to be regretted that he has so decided, as the few of us privileged to meet him were charmed with his delightful conversation of some four hours. Many topics were mentioned and discussed at length or briefly, according to their import. Some of those of interest to the profession I shall mention.

*Consumption* is a disease common in that country. No accurate statistical statement can be made as to the number of cases in proportion to population. Their sanitation has not been so far advanced as to establish health officers and boards of health, thus giving such statistics. Not much can be found of modern scientific knowledge and research in a country where it requires three men to use an American shovel, and where the old Abrahamic plow is their only means of upturning the soil. Yet they have believed and taught for years—I was about to say centuries—that consumption is a contagious disease. We are not lacking in men of intelligence who still disbelieve it. Nature has done a great deal for the races of the world. The intuitions of ignorance are frequently as accurate as the conclusions of intelligence established by careful investigations.

*The morality* of the natives is low among men, and high among women. The native woman, unchristianized, is very rarely unchaste so long as she is not married. She never appears in public unveiled. It is a good practice, as she is not a handsome creature. I'm not so sure but that such a fashion would be a great advantage to many English speaking females.

After these women are married the rules of chastity are not obeyed so strictly. Houses of prostitution are common and are filled mostly with divorced persons. Divorce is so easy that such women are abundant. When a husband says to his wife in the presence of witnesses "I divorce you," she is no longer his wife. What a boon such a law would be to the theatrical profession in America! Gonorrhœa and other diseases resultant from prostitution are prevalent.

Gonorrhœa of the rectum is frequent

from the fact that sodomy is about as general as prostitution.

*Urinary Calculus* is of very frequent occurrence. Dr. Kay has operated several times when Dr. Post who is in charge of that department has been absent. The last named has operated over three hundred times. The native doctors also operate, but in a very crude and dangerous manner—and without antiseptics.

*The age* at which the women marry is generally from twelve to fourteen years. Occasionally as young as ten years. Dr. Kay knows a lady 21 years old who is a grandmother. She was married at ten. The physical development is not perfect at so early an age, but quite sufficient for child-bearing and suckling of offspring.

An amusing thing related by the doctor occurred during a visit to the Governor of Cæsarea Philippi. The Governor was quite fond of his country and of the trees. He showed them a small tree about eighteen inches in diameter and asked with much self-assurance if there were such *large* trees in America as that one? Not wishing to "paralyze" the old gentleman by a description of a California tree, the doctor simply remarked "sometimes."

MEDA.

HOW TO ADMINISTER COD-LIVER OIL TO INFANTS.—A good suggestion has been made by Yeldham, of a plan of administering cod-liver oil to infants. Let the nurse dip the end of her little finger in the oil, and put it into the child's mouth. This may be repeated five or six times in the twenty-four hours. In such small quantities, not only does it never disagree, but the child sucks it off the finger with avidity and evident pleasure. It may be administered in this way to the youngest infant. By this simple and inexpensive expedient Dr. Yeldham says many infants who were absolutely starving for natural foods became fat and plump, and happily in an almost incredibly short space of time. The oil has the effect of enabling the child to digest other food, which it could not retain on its stomach without it.—*Med. Record.*



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BALTIMORE, OCTOBER 16, 1886.

**Editorial.****"HAND-CRAFT AND REDE-CRAFT."**—

Under the above title Prof. D. C. Gilman, of this city, contributes an article to *The Century Magazine* (Oct. 1886), which is well worthy of careful study consideration by all who are interested in the educational and social problems of our age. A great deal is included in these words. The power of the hand to hold, shape, match, carve, paint, bake, plow, or weave, and the power to read, to reason and to think are among the great forces at work in the development of human destiny. Prof. Gilman undertakes to show how rede-craft is the friend of hand-craft, how these two brothers should work together as right hand and left hand, as science and art, as theory and practice. Whilst rede-craft calls for books, hand-craft calls for tools, and by the help of both books and tools mankind moves on.

"Their union is as sacred as the marriage tie; no divorce can be allowed. The pleasure and profit of modern life depend upon the endurance of their joint action."

Prof. Gilman enters a plea for hand-craft and remarks upon the wrong which so many people commit, some whose minds are full of ideas and some whose purses are full of gold, in looking down upon hand-craft. These people have never tasted the pleasure of making, the delight there is in guiding the fingers by the conscious and planning will. "They think only of the tasks of a slave, a drudge,

or a char-boy." Prof. Gilman contends that the market, which is poorly supplied with those who are trained in the higher walks of hand-craft, is over-stocked with those who would follow in the walks of rede-craft. Young men who are poor in pocket and rich enough in talent to go to college, allow their mothers and sisters to toil for their support, and many more accept the gifts of unknown helpers, not because they prefer to do so, but because they have not learned to produce with their own hands anything which the world is willing to pay for.

"To some extent machinery works against hand-craft." That which embodies the inventor's mind, takes the place of the mind in the workman. "He who lives by the machine alone leads but half a life, while he who uses his hands to cultivate and adorn, drives dullness from his path."

Professor Gilman argues that if we really value hand-craft we can find many ways of giving it honor. And he then enters a plea for the education of the young in hand-craft while they are getting rede-craft. Mothers, he contends, should begin right in the nursery, teaching little fingers to play before the tongue can lisp a sentence. "Alas, this natural training has too often been stopped at school. Books have claimed the right of way; rede-craft has taken the place of honor; hand-craft has been kept in the rear."

One of the most encouraging signs of the times is the change which is coming in schools of every grade. The changes begin at the top of our educational system and are fast working down to the bottom. Our laboratories, working-rooms, labor-places have become temples of hand-craft, just as the book-rooms, reading rooms, libraries are the temples of rede-craft.

In the lowest schools, "the kindergarten methods have won their place, and the blocks, straws and bands, the chalk, clay and scissors are in use to make young fingers deft."

For the promotion of hand-craft Prof. Gilman recommends for preliminary needs. First, kindergarten work in nurseries and infant schools. Second, every

girl should learn to sew, and every boy should learn to use domestic tools. Third, well-planned exercise fitted to strengthen arms, fingers, wrists, lungs, etc. Fourth, drawing should be taught as early as writing and as long as reading, for all, and everywhere.

"At every stage of education," Prof. Gilman remarks, "the language of the pencil and the pen must be employed, rede-craft must be practiced with hand-craft; and there must be no thought of immediate profit from that which is done in the early and rudimentary stages of training."

What interests have physicians in the powers of hand-craft and rede-craft? Clearly the deepest. In professional training and in professional work the higher skill in the use of the fingers and arms is as much in demand as the power to think, to reason and to judge. We can not divorce these two brothers in our science and art. Rede-craft may call for books, but hand-craft calls as loudly for tools. Medicine is an art as much as a science; it is a practice as much as a theory. The success and profit of medical work are interwoven in the development of the powers of hand-craft and rede craft. The early training of the medical student should consist in the exercise of his fingers and arms. He should learn to dissect, to draw, to manipulate with instruments of precision, to practice complex movements with his fingers and arms, in fact, to become skilled in professional artisanship. Again, his special senses require careful training and development. His touch, taste, smell, hearing and seeing, are essential faculties in the acquisition of knowledge. His ability to perform professional work depends as largely upon the training of these organs as upon his book-learning, or his power to reason or to think. Rede-craft and hand-craft must be equally blended in his accomplishments. The one must serve the other, and both must acquire their development side by side. Hand-craft in medicine has been made secondary to rede-craft. The power of working with the hands has been less popular than the ability to work with the head. We enter a plea for the

former. We believe that the profit of medical work depends upon "the endurance of their joint action." Let those who educate our medical students consider the value of hand-craft. Let them make the tasks of the hands as profitable as those of the head, and we will have more skillful surgeons, more painstaking chemists, and more accurate diagnosticians and microscopists. Instruction in the arts of hand-craft should begin when studies in rede-craft have been entered upon. It would be an excellent exercise for the fingers and arms if students, contemplating or entering upon the study of medicine, would practice with the knife and scissors, with needle and thread in dissecting the lower animals or birds. Advantage might be taken of the opportunity which is often presented of assisting in the slaughter-houses of large cities or villages. Here a practical knowledge of the tissues and organs of animal life could be obtained, and manual dexterity acquired in preparing and handling these tissues. This introductory to the higher art of dissection would occupy a valuable position as a preparation for professional artisanship. But even subsequent to graduation in medicine hand-craft should remain as a practical accomplishment, rather than a lost art.

The physician needs dexterity of touch, keenness of sight and hearing, gentleness and skill in manipulation, if he would become an accurate and expert diagnostitian, an adept in the use of instruments, an artist in the broad field of surgical adventure. He may obtain the training of his various senses and faculties in the dissecting room, in the laboratory, in the hospital ward, in the dispensary or in general practice. No matter when or how obtained hand-craft is as essential to his success as a practitioner of medicine as is rede-craft. To be able to do is no less important than to know the method by which a thing is done. It is the application of knowledge that gives pleasure and success to the educated man.

During the present week all of the Medical Societies of Baltimore, will have resumed work for the Winter.



## Book Reviews.

*Text Book of Human Physiology.* By Dr. L. LANDOIS, Professor of Physiology, University of Greifswald: Translated by Wm. Stirling, M.D., Sc.D., Professor of Physiology in Owen's College, Manchester, etc. Second American from the fifth German edition. Philadelphia: P. Blakiston, Son & Co.

There are several points of special importance that commend the book before us to both student and practitioner. In the first place it is a complete work in physiology; nothing that could come within the comprehensive term has been omitted. The author touches here and there in a delightful way on the history of special organs, and traces briefly the progress that has been made in physiological study from century to century.

Then the work has been brought up to date, including almost all of the recent discoveries in histology, physiological experiments and the method of performing them, and the newly invented instruments, of which latter there are many carefully executed plates.

Finally, the book possesses to a high degree what the translator claims for it *practicality*; not only does it give the reader an account of the experimental work which is sufficiently clear to enable him to repeat it for himself, but the connection between physiology and practical medicine is insisted upon at every page.

Altogether the book is an exceedingly valuable one, and the rapidly exhausted editions attest the fact that the author's work has not been unappreciated by the profession.

*Massage.* By WM. MURRELL, M.D., F. R.C.P. Philadelphia: P. Blakiston, Son & Co. For sale by Cushings & Bailey, Baltimore.

The *brochure* before us contains a rather startling account of the wonderful working power of massage. In fact we feel that we have been remiss in not using it in *all* intractable diseases, for our author gives instances of its efficiency in many forms of paralysis, dys-

pepsia, constipation, rheumatism, syphilis rickets, corpulence, 'fidgets', and a host of other affections.

However, our mind is released by the statement that a *masseur* or *massuse* must be thoroughly educated to it, and from the qualifications noticed as requisite we know that such persons are hard to get.

The author quotes many allusions to what he infers to be massage in the writings of Hippocrates, and, of course among the Chinese.

This method of treatment certainly has its place, but we doubt if its applicability is as extensive as our author thinks. There is a significant note or warning at the end of the volume in which it is stated that many professional 'rubbers' exercise their talent to excite the sexual feeling, and the physician is advised to attend each *séance*.

*Diseases of the Ear.* By URBAN PRITCHARD, M.D., F.R.C.S., Professor of Aural Surgery at King's College, London, etc. Philadelphia: P. Blackiston, Son & Co. For sale by Cushings & Bailey, Baltimore.

This little book, of less than 200 pages, belongs to a class that is very useful to the general practitioner. Without being diffuse or technical, it gives the man who is too busy to consult the voluminous works on the subject, the results of special investigation and experience, and makes him familiar with the methods by which such results are brought about. The introductory chapter is devoted to the anatomy and physiology of the ear, which is simplified by a number of clear diagrams. The various diseases of the ear are discussed in a concise way, and only the indispensable instruments described. The author lays especial stress on the danger of using anything but the syringe for the removal of cerumen and most foreign bodies, and where it becomes necessary to employ the ear forceps or scoop, urges the utmost caution in the application of them.

In the appendix will be found a number of useful formulæ, and the index, a very important thing in a hand-book such as this, has been carefully prepared.

### Miscellany.

REFLEX AURAL SYMPTOMS WITHOUT AURAL DISEASE. AURAL DISEASE EXCITING REFLEX SYMPTOMS.—This subject has, as yet, been very imperfectly recorded in the literature of pediatrics, and yet is of considerable importance in the symptomatology, prognosis, and treatment of children's diseases. A careful consideration of the subject by Drs. C. J. Blake and T. M. Rotch, in the October number of *The American Journal of the Medical Sciences*, is timely. They point out the direct channel of nerve communication between the source of irritation and the vascular supply of the auditory structure.

Incidentally to the discussion of the subject of "dental irritation," they say a few words about gum lancing—a procedure which in former years was so universal, and at the present time is discountenanced to an equal degree by certain writers of authority in pediatrics.

During the dental periods two classes of irritation are met with.

1. Irritation of the dental nerves from pressure in the bone socket caused by pressure at the root of the growing tooth, and the accompanying symptom is commonly spoken of as "teething;" in this class of cases we especially have the reflex earache spoken of as above.

2. Irritation of the gum over the crown of the tooth from pressure, with symptoms of local irritation causing fever, and with general nervous symptoms. Now we have here two exactly opposite conditions: 1. Pain from pressure at root of growing tooth. To relieve the symptoms of (1), we can easily see that lancing the flat, soft, unirritated gum can be of no possible use; while what better treatment can there be for the symptoms of (2) than freely to lance the hot, swollen, and tense gum, as we would where it is possible in any part of the economy to relieve symptoms of pressure by abolishing the cause of the pressure. We should lance, then, not as formerly in every case, but knowingly in the class of cases where our common sense tells us that the gum is crying out for the lancet as plainly as the felon demands the bistoury.

Drs. Blake and Rotch point out how aural disease can produce reflex pulmonary symptoms and reflex laryngeal cough, and in turn true pulmonary disease, dental irritation, the exanthemata, and superficial cutaneous disturbances may produce aural symptoms.

Rational treatment of these cases, then, can only be accomplished by a thoroughly scientific anatomical and physiological knowledge of the reflex phenomena, which from the hypersensitive condition of the child's nervous system, play a much greater rôle in childhood than in adult life, and render a diagnosis much more difficult.

We must admit the great importance of recognizing whether symptoms are real or reflex, tracing them from one end of the labyrinth of nerves to the other, and following them out with the minutest detail, for in this way only can we speedily reach the goal of recovery through definite and exact diagnosis, with resulting appropriate prognosis and treatment.

THE NATURE OF JAUNDICE.—Following in the lines of M. Chauffard, Prof. Kelsch, of Val de Grace, writes in support of the specific nature and infective origin of catarrhal jaundice (*Revue de Méd.*, Aug., 1886). He confirms the clinical observations of M. Chauffard, especially as to the urinary excretion, but is unwilling to accept the doctrine that the condition is due to ptomaines formed in the intestinal tract, regarding an external agent as more probable. The observation of epidemics of jaundice in the army, of which he records instances, points to the conclusion that they are due to telluric conditions, and therein establishes a link between catarrhal jaundice and malignant jaundice. The latter is mostly admitted to be due to foul water-supply or bad drainage; and both varieties are frequently associated in epidemics. M. Kelsch, indeed, avers that the simple and malignant forms are one and the same affection, and therefore sums up his belief in the propositions that (1) sporadic or epidemic catarrhal icterus is a specific, infective disease; (2) that the infective agent is developed outside the organism; (3) that it



is generated in marshes and in soil abounding in animal and vegetable matter; and (4) that owing thus a common origin with malaria and typhoid fever, the coincidence of epidemics of jaundice with ague and typhoid is explained.—*Lancet*, Sept. 4.

ABNORMAL VISUAL SENSATIONS.—With increasing knowledge and improved methods of diagnosis, most of the cases formerly classed as amaurosis or amblyopia are now relegated to their proper position on the list of more definite diseases of the eye; but meanwhile slight errors of vision, which were formerly unheeded, have been brought into notice, some of them only within the last year or two. Amblyopia, Mr. F. R. Cross points out in the October number of *The American Journal of the Medical Sciences*, thus continues to be a generic term, including all cases of dull sight in which no distinct lesion of the eye can be discovered; it expresses in a general way, the failure in function without indicating the pathological condition present. Subdivisions have been made according to the assumed cause of the affection; the assumption in some cases is supported by the strongest possible evidence, as in tobacco amblyopia; while, as more light is thrown upon the subject, the term hysterical amblyopia becomes less frequently used. The essential symptom is a partial or complete absence of perception, either of objects or colors, in some part of the visual field; the function is impaired or modified. A normal visual acuity varies with illumination; it is certain, therefore, that some amblyopias will be much modified by the amount of light.

Mr. Cross classifies the first cases according to the part of the visual field which is chiefly affected, and he points out that the evidence which has been derived from the pathological conditions present in those examined indicates that the position of the lesion is fairly constant for similar conditions of the visual field. In some a well-defined organic mischief has been shown to be present, either in the peripheral nerve terminating in the retina, in the cerebral centres,

or in the optic fibres connecting these; in others a definite cause exists for initial vascular disturbance of the nervous elements of the retina.

ON THE HYPODERMIC USE OF IODIDE OF SODIUM.—Dr. Arcari, of Mailand, as we learn from the *Wien. Med. Woch.*, No. 4, 1886, is in the habit of applying iodide of sodium hypodermically in cases in which the internal use of the drug has to be suspended on account of resulting gastric irritation. He makes two injections daily, the dose ranging from four to fifteen grains.

The results obtained by Arcari in syphilis with the hypodermic employment of iodide of sodium were quite as satisfactory as with any other mode of treatment. The quantitative examination of the urine revealed that in the cases showing favorable results of treatment the elimination of iodine proceeded slowly and scantily, while in the cases with negative results this elimination was quick and ample. This fact led Arcari to conclude that in the latter cases larger doses had to be given for a long time in order to obtain even here favorable results. To prevent an undue burdening and irritation of the alimentary channel, the alternate internal and hypodermic application suggests itself wherever large doses of the iodine salt are required.—*Ther. Gaz.*

THE TENDON-JERK AND MUSCLE-JERK IN DISEASE, AND ESPECIALLY IN POSTERIOR SCLEROSIS.—Drs. S. Weir Mitchell and Morris J. Lewis, believing that their recent researches on the knee-jerk have given to symptomatology an enlargement as to certain nervous maladies, in a brief paper, which appears in the October number of *The American Journal of the American Sciences*, they apply what they have learned to a single disease—posterior sclerosis of the cord. This disease was chosen because they were able to gather readily for examination a representative group of cases, and also because its natural history descriptions, having come from masters of their art, are both definite and reasonably complete.

The mechanical reactions of tendon- and muscle-jerks are found to alter in the following order: The tendon-jerk is lessened or lost, but can still be reinforced in the first stage. In all successive stages both are absent. Meanwhile the muscle-jerk, say of the extensors of the hand, is healthy in stages 1 and 2, and reinforceable in both. In stage 3 the muscle-jerk is normal, but there is no reinforcement. In stage 4, with station much impaired, the muscle-jerk becomes increased. It is quicker and larger, as Buzzard observed in 1878, and Erb also, but now it is irregularly distributed, and may be less in places, and cannot be reinforced. In stage 5 the muscle-jerk is lessened irregularly, and no reinforcement is possible. In stage 6, that of complete paralysis, rarely attained because death is apt to intervene, all the reactions, tendinous and muscular, and all reinforcements vanish. Of the chin-jerk, little can be said. It is sometimes absent in health, or is hard to get, and seems more common in stages 1 and 2 than in 3 and 4.

The various changes here mentioned probably represent, incompletely, the totality of alterations of muscles in posterior sclerosis. The gradual cutting off of spinal tone waves is shown in the successive loss of tendon-jerk and its reinforcement, and of muscle reinforcement. The increase of direct muscle-jerk which ensues may be due to some irritative changes in the muscle, not as yet to be fully understood. It is followed by lessening of muscle-jerk, and at last by paralytic loss of muscle reactions. Some microscopic studies of muscle tissues are still needed to explain these late phenomena.

While studying the effects of voluntary motion on the tendon and muscle-jerks it was noticed that associated movements occurred in many of the cases. Thus, on clenching the fist, movements occurred in the other hand, or even in one or other of the legs. This they discovered too late to note it in all their cases. It apparently belongs to an advanced condition of the disease. To observe it, the hand should rest in passive supination on the thigh, while the

opposite fist is being clenched; the patient's attention should not be called to the possible result of the experiment.

A new symptom, distinct prominence of the eyes, with a full appearance of the surrounding tissues not due to oedema, was found six times, chiefly in late cases.

ON CHLOROFORM-WATER.—De Beurmann recommends in the *Zeitschrift für Therapie* of April 1, 1886, diluted chloroform-water as an antifermentive agent, which is also a local anæsthetic for mucous membranes. It is also useful as a mouth-wash in toothache, and given internally in cardialgia and dilatation of the stomach. In various decomposition processes in the stomach, in vomiting (especially of pregnancy), and as a vehicle for sedative and narcotic remedies, chloroform-water is, in Beurmann's estimation, unexcelled. The following are some of his favorite prescriptions in which the chloroform-water is exhibited:

℞ Aquæ chloroformii saturat., f̄i;v;  
Aq. aurantii florum, f̄i;iv;  
Aq. dest., f̄i;iv. M.

S.—Teaspoonful for a single dose.

℞ Aq. chloroformii dilut., f̄i;iv;  
Aq. aurant. flor.,  
Syr. simpl., aa f̄i;i;  
Morph. hydrochlor., gr. ss;  
Pot. brom., gr. 15. M.

S.—Dessertspoonful several times daily.

℞ Aq. chlorof. dil., f̄i;iv;  
Aq. flor. aur.,  
Syr. papaveris, aa f̄i;i;  
Pot. brom., gr. 15. M.

S.—Dessertspoonful several times daily.

℞ Aq. chlorof. dil., f̄i;iv;  
Aq. menth. pip.,  
Syr. simpl., aa f̄i;i;  
Sodii salicyl., ʒi. M.

S.—Tablespoonful as a single dose.

—*Ther. Gaz.*

THE INFLUENCE OF GASTRO-INTESTINAL AFFECTIONS OF CHILDREN ON THEIR BODILY WEIGHT.—Dr. Nakatsu Miyamoto (of Japan) communicates to the *Arch. f. Kinderheilkunde*, 1886, vol. vii., Nos. 3, 4, the results of his observations on the influence of gastro intestinal troubles of children on their bodily weight. He examined for the purposes



stated, dyspepsia, ten cases; intestinal catarrh, fifteen cases; enteritis follicularis, eight cases; cholera infantum, six cases. His conclusions are thus formulated:

1. Dyspepsia invariably and manifestly decreases the weight, often causing a daily loss of thirty-three grammes (one ounce).

2. Intestinal catarrh has very similar consequences.

3. In enteritis the loss is far heavier, at times amounting to twenty ounces *pro die*.

4. Cholera infantum causes, of all stated affections, the greatest reduction in weight in the shortest time, amounting occasionally to a loss of one-tenth of the entire weight within twenty-four hours.

These cases, of course, are all fatal.—*Ther. Gaz.*

THE LOCAL TREATMENT OF PSEUDO-MEMBRANOUS CROUP; INTUBATION OF THE LARYNX.—Dr. J. Lewis Smith, in an article in the October number of *The American Journal of the Medical Sciences*, expresses his belief that intubation is destined to be employed more generally than tracheotomy in the treatment of pseudo-membranous croup. He maintains that in all cases in which the obstruction is limited to the larynx and trachea, intubation relieves the dyspnoea as quickly, effectually, and permanently as does tracheotomy. It gives, in most instances, complete relief for a time. If the respiration subsequently become embarrassed, and no benefit occur from cleaning the tube, tracheotomy may be required. Intubation may properly precede tracheotomy in most cases.

Not a few parents, in the middle and lower classes, allow their children to die rather than consent to this operation. On the other hand, few parents will object to intubation, and when they see the relief which it produces they will probably consent more readily to tracheotomy if the dyspnoea should return. If only one of these operations be performed, statistics thus far show nearly as good a result from intubation as from tracheotomy.

Now that diphtheria has become so common the physician should be provided with the necessary instruments for intubation whenever diphtheria appears in his locality. Alkaline and trypsin inhalations, properly and almost constantly used, and intubation performed early, when the patient begins to suffer from dyspnoea, would probably prevent the necessity of tracheotomy in a large proportion of instances. But if such treatment do not fully relieve the dyspnoea, it will, in most instances, so diminish it and retard the progress of croup, that the physician, remote from help and unfavorably situated for the performance of tracheotomy, will have ample time to prepare for this operation. Intubation may prevent the need of tracheotomy, but if not, it presents no hindrance to it.

INFANTILE CONSTIPATION.—Dr. Louis recommends:

R̄ Mannæ opt. . . . 3i,  
Magnesii carb. . . . 3j,  
Ext. sennæ. fl. . . . 3ij,  
Syr. zingiberi . . . 3j,  
Aqua . . . . . 3ij.

M. Sig.—One teaspoonful two or three times daily.

R̄ Resinæ podophyli, gr. ½  
Spts. vini rect., m̄ xv,  
Syrup, . . . . . 3j

M. Sig.—One teaspoonful at bedtime.—*Med. Bulletin.*

YELLOW FEVER; ITS TRANSMISSION BY THE CULEX MOSQUITO.—Dr. Charles Finlay, of Havana, maintains in an article which appears in the October issue of *The American Journal of the Medical Sciences*, that yellow fever is not spontaneously transmissible by infection through the air by contact, but that it may be artificially communicated by inoculation, and only becomes epidemic when such inoculations can be verified by some external natural agent, such as the mosquito.

The history and etiology of yellow fever exclude from our consideration as possible agents of transmission, other

blood-sucking insects, such as fleas, etc., the habits and geographical distribution of which in no wise agree with the course of that disease; whereas a careful study of the habits and natural history of the mosquito shows a remarkable agreement with the circumstances that favor or impede the transmission of yellow fever. So far as Dr. Finlay's information goes, this disease appears incapable of propagation wherever tropical mosquitos do not or are not likely to exist, ceasing to be epidemic at the same limits of temperature and altitude which are incompatible with the functional activity of those insects; while, on the other hand, it spreads rapidly wherever they abound. From these considerations, taken in connection with his successful attempts in producing experimental yellow fever by means of the mosquito's sting, it is to be inferred that these insects are the habitual agents of its transmission. It cannot be denied, however, that other such agents may and probably do occasionally occur, but not being endowed with the same facilities for rapid and extensive operation, their influence becomes insignificant as compared with the action of the Cuban culex.

GASTRIC CATARRH.—Professor Da Costa often orders—

R Argenti nitratis - - - gr. ij.  
Ext. hyoseyami - - - gr. ij.

M. Ft. pilulæ No. xii.

Sig.—One pill three times a day.

GASTRALGIA.—

R Tinct. stramonii - - - 3 ss.  
Tinct. hydrastis - - - 3 iv.  
Aqua lauro-cerasi - - - 3 iiss.

M. Sig.—One teaspoonful in water every four hours.

—*Exchange.*

INSANITY AND CRIME.—Dr. Richard J. Kinkead in the October number of *The American Journal of Medical Sciences* discusses at length the relation of crime to insanity, and controverts the views expressed by

Lord Bramwell in the late number of *The Nineteenth Century*.

Dr. Kinkead believes that madmen who have committed criminal offences should be sent to an asylum. If an insane man commits homicide, he should be confined in an asylum for life; the protection of society demands this, not only to guard against a repetition of the act by the lunatic himself, but to prevent simulation of insanity by the sane. Imprisonment for life with lunatics would be to the sane far greater punishment than penal servitude—to many, worse even than death. For less offences he should be confined in an asylum till cured. To punish a man for having a disease, or for the acts which his disease compels him to do, is unjust.

To remove a madman to a place where his disease will be properly treated, and where he cannot injure others, is just, politic, and humane. Penal discipline is injurious to the insane; lunatics cannot be kept in prison; not only because it is detrimental to them, but because their presence is subversive of discipline, and a constant danger to the other prisoners and to the officers. Whether a man is mad or not can be decided only by those who have experience of insanity—that is, by experts.

The law as it stands, Dr. Kinkead holds, is a wrong law; it tries to define what is indefinable; to create a disease which does not exist; it withdraws from the jury matter of fact, and establishes tests which experience has shown to be utterly fallacious.

Lord Bramwell thinks it hard to say why lawyers generally supposed sharp enough should go wrong on this particular subject. The answer is simple: their education and training have not fitted them to deal with it. Versed in metaphysical lore and legal subtleties, they have not studied physiology or pathology, nor acquired experience of the insane: just as no amount of book learning alone will enable a physician to deal with sickness, or a surgeon to operate; so no mere mental philosophy or legal training will enable a lawyer to grapple with the paradoxes of insanity. If lawyers were obliged to spend six



months in an asylum studying mental diseases, they, too, would be quite as anxious as doctors are that the law should be changed, and would be just as convinced that it is wrong, as Lord Bramwell is that it is right. Nor would they fall into the error of considering madness not a disease of the body; for whether we look upon mind as the product of the brain or merely working through it, it is disease, functional or organic, of the organ, which is either its origin or instrument, that constitutes madness.

RELATIONS OF BACTERIA TO THE SOIL ON WHICH THEY GROW.—Mr. W. Watson Cheyne, having discussed, in the July issue of *The American Journal of the Medical Sciences* the conditions which favor or hinder the growth of bacteria, presents in the October number a study of their mode of nutrition and the changes which take place in the soil in which they are growing. This subject is an abstruse one, owing to the complexity of the chemical substances which are used as food, and the difficulty of ascertaining by analysis the precise changes which have occurred. Hence relatively little is as yet known about these matters. He considers in detail the mode of assimilation of nutriment by bacteria, the source of their energy, the respiratory processes, and the products of their growth, especially the production of pigments, the formation of ptomaines, and the various fermentations.

THE SURGERY OF THE PANCREAS, AS BASED UPON EXPERIMENTS AND CLINICAL RESEARCHES.—Dr. Senn continues his elaborate study of the surgery of the pancreas in the October number of *The American Journal of the Medical Sciences*. In connection with the subject of wounds of the pancreas, he strenuously maintains that complete extirpation of the head of the pancreas with the common duct is never justifiable, and that operations upon this portion of the gland for injury or disease, for the present at least, must be limited to partial excision of the head, with preservation of the common duct.

He finds that cirrhosis or chronic interstitial pancreatitis sometimes produces stenosis of the bile-duct or the pancreatic duct, and that, when the obstruction is followed by retention of the secretions, an operation becomes always necessary in biliary retention, which should be treated by establishing a new outlet for the bile into the duodenum, while the formation of an external pancreatic fistula in cases of cyst of the pancreas becomes necessary only when the presence of the swelling in itself has become a sufficient source of pain and discomfort to warrant treatment by abdominal section.

In pancreatic abscess he holds that a positive diagnosis of the presence and precise location of the abscess is only possible by resorting to explorative laparotomy, and that this should be always resorted to when the history of the case and the symptoms point to a probable diagnosis. The abscess found and located by abdominal section should be removed by partial extirpation of the pancreas when it is endopancreatic and located near the splenic end of the pancreas. When extirpation is impossible, or when it is located in the head of the pancreas or on the anterior surface of the pancreas, it should be treated by the formation of an anterior abdominal fistula; when located behind the pancreas, by through drainage, or lumbar drainage performed through the abdominal cavity.

The propriety of surgical treatment of pathological hemorrhage of the pancreas should only be entertained when the accident takes place in consequence of circumscribed, benign, pathological conditions, which in themselves do not jeopardize the life of the patient, and which admit of measures for arresting hemorrhage by direct treatment. Operative interference should therefore be limited to hemorrhagic cysts of the pancreas. In well-defined cases belonging to this group, it would be justifiable to resort to abdominal section as the only means of arresting fatal hemorrhage, by direct ligation of the bleeding points, or by removing such localized portions of diseased tissue from which the hemorrhage has taken place.



### Medical Items.

The title of the first Original Article in the present issue of this JOURNAL should read. "A Short Note on Two Cases of Traumatic Aneurism Cured by Pressure."

The *Medical Record* credits Prof. Schröder, of Berlin, with a fee of 10,000 marks (about \$2,000) for performing the operation of myofibroma.

The Paris Municipal Council, after a heated discussion, has voted to extend the concession of the site for the proposed Pasteur Institute, in Rue Vauquelin, from thirty to ninety-nine years.

Prof. Bartholow teaches that the best way to treat poisoning by corrosive sublimate, is to get all the eggs possible into the patient, and then bring about prompt emesis.

The American Public Health Association at its recent meeting in Toronto, Canada, elected Dr. G. M. Sternberg, of the U. S. Army, president for the ensuing year.

The *London Medical Record* reports the case of a man admitted into a hospital with a chancre on his left eyebrow. The man stated that during a quarrel three months previously he had been bitten by his antagonist on the left eyebrow.

New York boasts of thirty-one different Medical Societies, all of which resume work during the present month. These societies meet monthly and semi-monthly. On an average there are seven or eight meetings every week in the city.

The American Academy of Medicine concluded its sessions in Pittsburg on Wednesday of this week, and adjourned to meet in Washington, D. C., in September, 1887. The following officers were elected: President, Dr. L. P. Bush, Wilmington, Del.; Vice-Presidents, Drs. R. Lowry Sibbet, Carlisle, Pa.; Samuel J. Jones, Chicago; Phineas T. Connor, Cincinnati; Virgil P. Gibney, New York; Secretary and Treasurer, Dr. R. J. Dunglison, of Philadelphia.

At a meeting of the Gynecological and Obstetrical Society of Baltimore, held December 12th, the following officers were elected for the ensuing year, President, Dr. W. T. Howard; Vice-Presidents, Drs. P. C. Williams and A. F. Erich; Secretary, Dr. W. E. Moseley; Treasurer, Dr. R. T. Wilson. The Society has nineteen members and meets on the second Tuesday of each month at the residence of its different members in alphabetical order. The work of the Society is attested by its reports which have been regularly published in this JOURNAL.

The *Medical News* relates the following: "It has recently come to light that the State of New York, in 1806, paid to John M. Crous a thousand dollars for a remedy against hydrophobia which he considered infallible. The

measure was advocated by Dewitt Clinton and Chancellor Kent. This remedy consists of one ounce of the jaw-bone of a dog, burned and pulverized; the false tongue of a newly folded colt, dried and pulverized; and a "scruple of verdigreas," raised on the surface of old copper by laying it in moist earth. The warrant of the Comptroller on which the money was paid, and the receipt of Crous, are on file with other State papers at Albany."

The *Medical Record*, in a recent article on "The Long-Beard Habit," undertakes to show that the long beards frequently worn by physicians are not only dangerous as carriers of contagion, but are almost invariably associated with mediocrity of talent. "Hardly a doctor of the first eminence in the world's history ever wore a long beard," says our contemporary, "and he who possesses one may as well concede at once that he will never rise above mediocrity. In the long list of distinguished English and American physicians, from Linacre and William Harvey to John Hunter and Benjamin Rush, there are only beardless or shortbearded faces." "Reviewing the history of medicine it almost seems that the greatness of medical men is universally proportional to the amount of hair grown upon the chin! At any rate, we trust we have successfully shown that long beards are not the things for doctor, but are unhygienic, barbaric, and inconsistent with great historic precedents and the attainment of the highest professional eminence."

The seventeenth annual meeting of the Medical Society of Virginia, which meets at Fredericksburg on the 26 and 27 of this month, promises to be a most interesting occasion. The following programme has been announced:

Dr. Hugh T. Nelson will deliver the annual address to the public and the profession, on "The Fallacies of Modern Medicine." The president's address, by Dr. Rawley W. Martin, will be on "Some Practical Hints in Hygiene." This will be followed by a general discussion on "Puerperal Septicæmia." Reports on advances in medicine will be presented as follows: Anatomy and physiology, by Dr. James A. Anderson; chemistry pharmacology, materia medica, and therapeutics, by Dr. R. M. Slaughter; obstetrics and diseases of women and children, by Drs. Jacob Michaux, Hugh M. Taylor, and John F. Winn; surgery, by Dr. George B. Johnston; practice of medicine, by Dr. John S. Apperson; hygiene and public health, by Dr. A. Z. Koiner; ophthalmology and otology, by W. L. Robinson; and psychology and neurology, by Dr. I. S. Stone. The following papers will be read: "Some of the Causes of our Slow Advance in Therapeutics," by Dr. John Grammer; "Puerperal Eclampsia," by Dr. Bedford Brown; "Chloroform and Chloral in Childbirth," by Dr. H. M. Clarkson; "Laparotomy for Wounds of the Intestines," by Dr. Lewis Wheat; "The Etiology of Zymotic Diseases," by Dr. M. A. Rust; "School Hygiene," by Dr. J. H. Claiborne; and "Christian Burial vs. Cremation," by Dr. W. W. Parker.



## Original Articles.

## SOME OBSERVATIONS DURING TWO YEARS' RESIDENCE AT COLORADO SPRINGS, COLORADO.

BY J. T. ESKRIDGE, M.D.;

Read before the Philadelphia County Medical Society, September 22nd, 1886.

I will endeavor, in as brief a space as possible, to make some practical remarks concerning Colorado Springs as a health resort for consumptive patients especially. For what I shall have to say of the climate I shall rely mainly on my own observations, made during the two years that, as an invalid, I have resided there. In regard to the effects of the climate on phthisis, I will to try sum the results of the experiences of the principal physicians of the place, and give them, together with what I have observed. I am not ignorant of the fact that you can find over-painted descriptions of Colorado climate. So you may of every other climate that is supposed to have a beneficial effect on lung troubles. To such a degree have the climatic virtues of different places been lauded that disinterested physicians have come to have but little more confidence in the greater portion of the statements made in articles written by physicians who reside and practice at these various health resorts, than they have in the exaggerated accounts of the healing powers of some patent medicine; and as the nostrum is praised simply because it pays, so physicians do not altogether escape suspicion, or even censure, of being influenced by mercenary motives in their comparisons of the relative advantages of different climates. The truth is, it is very difficult not to allow one's self to become over enthusiastic concerning the merits of a place in which you find so many who were failing rapidly before leaving their homes, able to enjoy life, live in the open air, and frequently resume business again. That I may escape any suspicion of being influenced by a mercenary motive in writing this paper, I will state, that since I have been at Colorado

Springs, I have done no general practice, nor do I intend to resume it there. From time to time, I have had cases of lung trouble referred to me by Eastern physicians, but I have invariably refused to attend them. I am glad to have this opportunity to say, that there are a number of good physicians residing there. I have never before been in a place of its size where so much intelligence and talent in the medical profession was to be found. The greater portion of the physicians who reside there have been compelled to go to Colorado on account of their health. Most of them are graduates of some of the best medical colleges East. I am sorry to have to say that you will also find a number of irregular physicians there.

*Climate.*—I wish to remark, in pre-facing this subject, that the longer one has resided in Colorado, the less certain he is regarding weather prognostics there. For convenience sake, the year may be divided into two seasons, the wet and the dry. The former usually begins in April and ends in September or October. From October to April, as a rule, there is no rain. During a large portion of the wet season it is the rule to have daily showers in the early part of the afternoon, lasting from half an hour to an hour, the remainder of the day being clear. In the latter part of June and the early portion of July of the present year, there was a dry spell of several weeks' duration, with almost no rain at all. Most persons who visit Colorado are prepared to expect the daily showers, during the rainy season, but what they are not prepared for, and what not infrequently makes many suspicious of the reputed dryness of Colorado weather, is the occurrence, once or twice annually, of rainy spells of weather, lasting two, and sometimes, three days. During a portion of these times it rains as hard as I ever saw it along the Atlantic coast. So much for the rainy season. I have seen it stated that no rain falls there from the last of October till March; yet, during last winter I remember two light showers. They did not last long, nor did much water fall. Some persons who had

resided in Colorado Springs, for several years, told me that they never had seen rain there before doing the winter months. I should not consider these showers of sufficient account to deserve mention, were I not trying to give, as accurately as possible, my observations of the weather there for the past two years. No rain fell in the winter of 1884-85. During the winter repeated light snows fall, but they do not lie on the ground long; and evaporation is rapid and the soil porous, so that they disappear without leaving ground damp for more than a few hours after the snow is gone. While the snow is rapidly thawing in the hot sun, but little water is found on the ground, so that the days and weeks of terrible sludge so commonly experienced in many portions of the country are almost if not entirely unknown in Colorado Springs. It is in the cool dry weather that the air has the most invigorating effects. It sometimes may be said to be crispy and exhilarating. The warm season is much shorter than we find it in Philadelphia. Spring is late, in fact, this season seems to be largely dispensed with, and the change from cool wintry weather into mild summer heat is not uncommon. The years that I have been in Colorado, cool weather has begun the latter part of August, although it is frequently quite warm in the middle of the day, until late in September or the beginning of October. The warm season is but little over two months' duration. During this season the thermometer in the shade may rise from 90° to 100°, but as a rule only for a few days in succession. The summer just past seems to have been an exception in this respect, for we had a spell, of one or two weeks, of quite hot weather. During August of 1884 (the time when I first reached Colorado Springs), and the summer of 1885, I did not experience a night that one or two blankets were not necessary. In the hot, dry spell of July of the present year I could not endure a single blanket. From my experience, I should say that it is the exception not to find comfortably cool nights throughout the summer in Colorado. Evaporation is so rapid that

the heat is much less oppressive than we find it at the same temperature along the Atlantic coast. I never have found any difficulty in keeping comfortable on the hottest days whilst I was sitting quietly in the shade. The weather rarely gets very cold much before Christmas. Last winter no very cold weather was experienced until the first of January. The coldest weather occurs during January and February. The average temperature during these months is not very low (from 20° to 30°), but occasionally the thermometer drops to 20° or 30°. As the heat is less hard to endure, so the cold is less chilling and piercing in a dry than in a damp atmosphere. One will have to visit, in the winter, Colorado or some other place with a similar climate, and experience for himself, before he can realize fully, the difference in temperature between the shade and sun, even on the coldest winter day. During the winter, with the sun shining brightly, a thermometer exposed to the direct rays of the sun and protected from the wind will rise to 100° to 110°, whilst the temperature in the shade, probably not four feet distant, will be below 30°. On several occasions, in midwinter, while I have been sitting in the sun, I have been compelled to use an umbrella for protection, the shade temperature at the time being sufficiently cold to freeze. One of the great advantages of Colorado climate in the winter is the amount of time that invalids can be in the open air, although they may not be able to take much exercise. During the month of February of 1885, there were only three days that I was unable to sit in the open air, with entire comfort, from about 10 A.M., to 3 P.M. The hours of sunshine in Colorado, during the fall and winter, double, and probably treble, those along the Atlantic coast. The meteorological records, where three observations were made daily, show only three cloudy days for some winters. The observations, I have no doubt, are literally correct, but somewhat deceptive, if we were to understand by them that all the days but three of an entire winter were bright and sunny. At the hours when the observations are made



the sun may be shining, and twenty minutes after it may be cloudy, as it frequently is. These changes the records do not show. Observations which, when completed, will show the hours of sunshine each day for the entire year, are being made now at Colorado Springs, by means of the sun thermometer. I admit that an entire cloudy day, during the winter and fall is rare, but there are a number of raw and partially cloudy days that are too cold and disagreeable for invalids to be in the open air, unless they are strong enough to exercise sufficiently to keep themselves warm. Besides, there are some windy days that keep the weaker invalids in doors. A few words in regard to sudden changes of temperature. I have not infrequently seen it stated, by physicians, that in selecting a climate for consumptive patients we should choose one that is dry, free from high winds and great and sudden temperature changes. If you will reflect, you will realize that there is but little moisture in the atmosphere there can be but a correspondingly small quantity of the solar heat retained by it, so that after the sun has been shining for a number of hours, and sets, or is hidden suddenly by thick clouds, there must be necessarily a sudden fall in temperature.

The sudden changes in temperature may be attended by considerable wind. So common and sudden are these changes in Colorado, during the spring months especially, that no one who is prudent travels far from home or shelter without being prepared for such emergencies. You will find that when you have decided that your patient will do best in a dry climate, you must see to it that he is prepared, by a sufficient amount of strength, and good warm underclothing, to endure sudden changes of temperature, if he expects to live much in the open air throughout the year. Of course, if a patient is careful to always be where he can readily obtain shelter, he may not experience much inconvenience from the variations in temperature. Another point: a place that has a dry climate with a loose, porous soil, must of necessity have considerable dust stirring during the windy days. A dry climate with a

mild equable temperature is a thing that does not exist. Again, in high altitudes the air is more rarefied than at sea-level, and in consequence, a greater amount of breathing capacity is necessary for a person to breathe with ease and comfort. For the reasons that I have stated, consumptive patients, with little breathing room (unless it can be increased), or in the last stages of this disease, almost invariably do badly in dry mountainous regions, and die sooner than they will at low altitudes.

The question is often asked, How are persons in apparent health affected on going to an altitude of six thousand feet? I do not believe that persons in a good state of health experience any unpleasant sensations if they are careful not to exercise much on first reaching such an elevation, but the majority of persons visiting Colorado often make the mistake, on first arriving there, of exercising as much, or even more, than they were accustomed to do at sea level. The consequence is, that many such are troubled with irritable heart, shortness of breath after walking, and, what is more common, especially in persons beyond the age of forty, a full sensation in the head, a dull feeling in the ears, with some lessening of the acuteness of hearing. In about two weeks, such persons, if they have not continued to take too much exercise, apparently resume their normal condition. I have made a number of observations on the acuteness of hearing in persons who have lived some time in Colorado, and these have led me to believe that this sense is not so acute as we usually find it in persons living in a damper climate. This will be easily accounted for, when we study the effects of the climate on exposed mucous membranes. These are, briefly, dryness, hyperæmia, inflammation, and thickening. The dust, wind and dry atmosphere undoubtedly are the potent agents in producing these changes. Conjunctivitis, nasal and naso-pharyngeal catarrh, are very common. As a rule, there is not much discharge, the catarrh being of a dry, irritative character. The inflammation usually extends into the Eustachian tubes, and involves the middle ear.

The larynx does not escape, and an occasional hacking cough is not infrequent in persons who are otherwise apparently well. From what I have gleaned from the experiences of other physicians, as well as what I have observed, I think that all catarrhal affections of the air passages attended with much discharge are benefitted, usually on going to Colorado. My experience has been—and this is in accord with that of most of the physicians with whom I have conversed on the subject—that dry, irritative catarrhal conditions of the upper air passages, and of the middle and external ears, are made worse by residing in Colorado. It seems to be the almost unanimous impression with physicians whose opinions are entitled to consideration, that acute inflammations are sharper, and run a more rapid course, with, I think, less tendency to chronicity, than what we find of the same troubles at sea level. The physician who is sending patients suffering from phthisis to Colorado is desirous to know what cases most probably will do well there, and what ones he ought not to send. In my opinion, no positive information that will avail in every case can be given. Some, apparently the most desperate, do well, and on the other hand, others, which he may have many reasons to believe will be greatly benefited, grow steadily worse, or fail to improve. In trying to give some information that may help the physician to decide, I shall ignore most of the different varieties of phthisis as usually classified. I do this mainly because phthisis is studied clinically rather than pathologically at most health resorts. It must be exceedingly rarely that a post-mortem examination can be obtained on phthisical cases that die at Colorado Springs, for I have not been able to witness one there. Before endeavoring to specify certain classes of cases for Colorado climate, I wish to state that the physicians there are unanimous in their testimony to the fact that a prolonged residence causes an increased expansion of the chest. I am informed by some of the most careful that the circumference of the chest, on full inspiration, in-

creases from one and half to two inches during the first year. I think I am justified in saying that consumptive patients, in the last stages of the disease, especially if weak and nervous, or those who have in addition to their lung trouble an irritable, weak heart, due to valvular lesion or a weakened heart muscle, should not be sent to Colorado. An irritable heart caused by poor nutrition rapidly passes away as the general health is improved. Theoretically, there are two classes of cases that should not be much benefited, if at all, by residing in Colorado; one is plastic bronchitis, the other fibroid phthisis. Of the former, I know of only one physician who has a case. It has not been under his care long, but apparently it is doing well. It is well known that patients suffering from fibroid phthisis may live a long time in damp climates and at low altitude, especially if the climate is mild. But they do not get well; neither do they in Colorado. There they live comparatively comfortable for a number of years, taking much out-door exercise. The quantity of expectoration is greatly lessened, and its character improved, but increase in fibrous tissue goes on. From the irritative nature of the atmosphere there, we should expect that the increase of fibrous tissue would be more rapid than in a milder and damper climate. It is difficult to say whether the benefits derived from the lessened quantity of secretion, the aseptic condition of the atmosphere, and probably less tendency to bronchiectasis, do compensate for the irritative effects of the atmosphere. I have been informed, by one of the best and most experienced physicians of Colorado Springs, that he has never known a case of fibroid phthisis to terminate there by the development of tubercles. What the climate seems to offer in these cases is comfort, or amelioration of the effects of the disease—not a cure, and probably not as long a period of life to the patient. I have now to consider cases for which, if other things are favorable, there is little doubt about their being benefited by the climate of Colorado. The early hemorrhagic cases appear to do the best. It is almost, if not the



unanimous opinion of the physicians there, that the climate of Colorado is not only not productive of pulmonary hemorrhage in phthisis, but that these hemorrhages are less frequent in a given number of cases than they are found to be along the Atlantic coast, or in the States near the great lakes. I wish to emphasize the fact that these cases must lead necessarily a very quiet life during the first period of their residence in Colorado. It is obvious that if a case that is liable to bleed on slight exertion were to go there and exercise much before the ulcerated portions of the lungs had healed, hemorrhage would result, and probably to a greater extent than it would have done from the same amount of exercise at sea level. The tendency of ulcerated surfaces exposed to an aseptic atmosphere is to heal, and for this reason hemorrhages in the early stages of consumption are arrested. I have observed that pulmonary hemorrhage is rare there in persons who are prudent. In nearly every instance where pulmonary hemorrhage has occurred—and my own case is not an exception—the patient has had himself to blame for the bleeding. I will say nothing of the influence of the climate and altitude on the production of pulmonary hemorrhage in consumptive persons whose lungs contain large cavities, and who are in the last stages of the disease, for such cases should not be sent to Colorado. The effects of the dryness and aseptic condition of the atmosphere are clearly seen in lessening the secretion in cases where expectoration is abundant. Bronchial phthisis and the so-called catarrhal pneumonias do well. All those cases of phthisis in the incipient stage, provided the temperature is not too high, and the decided fever process is not kept up too long, improve rapidly. Persons suffering from phthisis may have a moderate rise of temperature, extending over a prolonged period, and yet improve, in Colorado. The fact that a person has a small cavity in his lung should not prevent his going to a high altitude, provided there is a large portion of healthy lung, and the patient is not too greatly reduced in strength.

All those cases embarrassed by conditions favorable for the development of tuberculosis, as indicated by heredity, poorly expanded chest, anæmia, loss of flesh, and often extreme weakness, usually receive great benefit from a *prolonged* residence in Colorado.

In this connection I wish to say a few words concerning heart troubles as influenced by the climate and altitude at Colorado Springs. We are told by some writers that all heart affections are increased by the altitude there. To suppose that because a person has a valvular lesion of the heart, he, in consequence, will be unable to live comfortably at an altitude of 5000 or 6000 feet, is an error. I have seen a number of cases of valvular lesion of the heart there, the physicians having been kind enough to allow me to study their cases. I know a few who have valvular lesions, and who work daily, without experiencing any difficulty. One of these is a poor woman who works very hard, and is not aware of her heart trouble. One patient, Dr. T. has well marked mitral regurgitation, and suffers from shortness of breath and cardiac asthma, when at Colorado Springs, but when she returns to her husband's ranch in the mountains, at an elevation of about 8000 feet, 2000 greater than that of the Springs, she feels comfortable. I certainly should not advise any one to go to Colorado for the cure of heart trouble, but when one is compelled to go there, the fact of his having a little roughness at one of the cardiac orifices will not be of itself a positive contraindication to his going. Cases of cardiac degeneration and enervation are the ones that suffer in Colorado, and in these the altitude may prove fatal. So long, then, as a case of valvular lesion of the heart gives rise to no discomfort, the compensatory hypertrophy being sufficient to compensate for the leakage or obstruction, there will be no difficulty probably, in living at a moderately high altitude. But so soon as the dilatation is greater than the hypertrophy and the heart muscle begins to weaken will a valvular lesion be a great obstacle to living in Colorado. Persons affected with fatty degeneration of the heart

should avoid high altitudes. Irritable hearts, due to a high sensitive, nervous system, bear exercise very poorly there. Irritable hearts, dependent upon weakness which is removable, do well.

It may be desirable to say a few words in regard to how invalids are affected on first going to Colorado. From what I have learned through the experience of other physicians and from my own observations, I do not believe that persons who are not extremely weak experience any unpleasant sensations. Invalids who go there and exercise too much soon after their arrival, as their feelings often lead them to do, soon begin to feel tired, and, perhaps, short of breath. Should a consumptive patient, on reaching Colorado, be attacked with spells of shortness of breath, without having exercised, it would be prudent, nay, urgent, for him to get away as soon as possible. Physicians, on sending their patients to Colorado or any other high altitude, should impress upon them the necessity of living very quietly. I am not exaggerating, when I state that many cases are made hopeless, annually, by too great and too violent exercise. Horseback riding is for the select few only. Long walks and mountain climbing should not be indulged in for the first year, nor afterward, without the advice and consent of a good physician. It is not infrequently the case that one meets with persons who are quite weak with pulmonary trouble, and who have been sent to Colorado, and told by their physicians to exercise all they possibly could, and to do considerable horseback riding. Usually, such cases as follow this advice break down rapidly, either from spreading of lung trouble, or from the of hæmoptysis. Cases, as a rule, will not find an immediate amelioration of their symptoms on going to Colorado, but, on the contrary, cough and expectoration are frequently increased the first few weeks or months. When I went to Colorado I was firmly impressed with the idea that if I ascended the altitude rapidly, I should probably bring on a pulmonary hemorrhage. I spent about a week traveling from town to town in Kansas, until I had reached an altitude

of about 2500 feet, when I determined to go to Colorado Springs at once. When I arrived there, I went immediately to bed, and was unable to tell, from my sensations, pulse, temperature or respirations, that I was so far above sea-level. I learned from the physicians there that a hemorrhage is the exception in persons just reaching Colorado, especially if they keep quiet. I now believe if the proper precautions are taken there is no necessity for invalids to ascend the mountains gradually. There certainly would have to be an urgent need to induce me to attempt it again. The great drawback is that there are but few places after beginning the ascent of the Rocky Mountains, where you can be tolerably comfortable before reaching Denver or Colorado Springs. The best time in the year for an invalid to go to Colorado is September. The rainy season is about over, and that portion of the year which is so delightful is just beginning. Patients improve most during the fall and winter months. If they do not lose some during the spring months they are fortunate. Those that are cured by Colorado climate are few in comparison with the many that are benefited and enabled to live comfortably for many years. A small number are able to return East and live, but those who thus venture to do so, and break down the second time, receive much less benefit on again going to Colorado. It should be a rule, from which there ought to be as few exceptions as possible, that when a consumptive patient finds a climate that agrees with him, he should there make his home for the remainder of his life.

In conclusion, let me say something of the advantages and disadvantages of Colorado Springs. It has nearly six thousand inhabitants, numerous churches and schools, good hotels, and a number of first-class boarding houses. There are two parks, and the streets and avenues are wide and shady. The water which supplies the city is the melted snow from the Pike's Peak region, and is as nearly pure as possible, and delightfully cool. It is conveyed several miles through an iron pipe which taps the stream in the mountains above the



point of possible contamination from human excremata. A large proportion of the inhabitants are intelligent professional and business men who have been unable to live East. It is very doubtful whether one could find another place the size of it, in this country, where so much intelligence, ease and comfort exist. A great many there live off the income of capital invested in other sections of the country. It is, in many respects, like a watering place, and in consequence, is far from being a brisk, lively, business town. It is possible to get nearly all the comforts there that can be obtained in a large city. The disadvantages are very great for those poor invalids who go there hoping to earn their expenses. It costs considerable to to live there and fare as well as consumptive invalids should. Table board at the best boarding houses is eight dollars per week. Board and room vary from ten to fifteen dollars per week. It is very difficult for many to get anything to do to aid them in meeting their expenses. These facts should be known by consumptive persons in moderate or needy circumstances, before they make the journey of nearly two thousand miles to regain their health in Colorado Springs.

I have endeavored to make my remarks as practical as possible. I trust I have succeeded without trying your patience.

## A DAY WITH PROF. PASTEUR.

BY ROBERT REYBURN, M.D.,

Professor of Physiology and Clinical Surgery Medical Department, Howard University, Washington, D. C.

During my recent visit to Europe, while in Paris I devoted one day to visiting Professor Pasteur's Institute for the purpose of treating hydrophobia.

I made my visit in the morning of August 10th, 1886, and it certainly was a most curious and interesting sight.

The Institute, or Laboratory so-called, is composed of quite a number of separate buildings arranged in the form of a

square, which are reached by a gate opening into a court yard in the centre of the buildings.

The hour of my visit was between 9 and 10 o'clock in the morning and already quite a number of persons were gathered together in the reception room, waiting for the coming of Professor Pasteur.

All ages and sexes were represented in the assemblage, from babes in arms to older children, and those who had reached the age of three score years and ten.

I was courteously received by the assistant, Dr. Grancher, and there seemed to be six other persons acting as assistants, some of whom were medical students.

Finally about eleven o'clock Professor Pasteur appeared accompanied by assistants who brought in the injecting virus in ten small glasses, each of a different strength, number one, which is the weakest, up to number ten which is the strongest; a vessel was also brought in containing a sterilizing fluid in which the needle of the hypodermic syringe was dipped before making each inoculation.

The inoculations were made by drawing into the hypodermic syringe a few drops of the diluted virus, which was then injected in the ordinary manner under the skin of the left or right side of each patient, just in the manner in which we give an ordinary hypodermic injection.

The number of injections usually given is ten, and these are given every second day, alternately on the left and right sides of the body.

The injections of course commence with the weakest virus, (number one) thence progressing until number ten, the strongest virus, is reached.

The dilute virus, used in these inoculations, is procured by opening the skulls of rabbits, and injecting into the medulla oblongata the hydrophobic virus; the wound is then closed and the rabbits do not seem to suffer much for a few days, but finally die somewhat suddenly about the tenth day, from convulsions.

The spinal cords of the rabbits are taken out, after death, and an infusion is made of the spinal cords, in veal broth, and this is the dilute virus which is used for the purpose of inoculation.

The first patient who presented himself was one who brought no evidence of suffering from anything other than an ordinary wound from the bite of a dog, and hence Professor Pasteur refused to inoculate him. The rest of the patients were in succession attended to, and the hypodermic injections of the virus were given to all patients present. The process extended over a period of about two hours.

A record is kept of the names, ages and localities from which the patients come, and Professor Pasteur requires, when it can be procured, a certificate from a veterinary surgeon, or physician, certifying to the rabid condition of the animal which inflicted the bite.

In regard to the personal appearance of Professor Pasteur, he is of medium height, full grey beard, partly bald and looks to be about sixty years old. He is still lame and evidently very weak on the left side of the body; this is the result of an attack of hemiplegia from which he suffered several years ago.

The statement was made to me by Dr. Thyssen, of Paris, who was present, that up to that date August 10th, 1886, about twelve hundred patients had been treated, coming from all parts of France, and out of that number only three had died. There were from other countries, including Great Britain and the other parts of the continent of Europe, and even from America, about six hundred persons treated, with only fifteen deaths.

It was stated also that the virus of hydrophobia, received by the bite of wolves, was much more virulent and fatal than that occasioned by the bites of dogs.

The number of cases given in the above statement, considering the rarity of the disease, seemed to be extraordinarily large, and to me almost incredible.

Entertaining, as I do, the profoundest respect for Professor Pasteur personally,

and for his past labors in the cause of science, yet I feel compelled to express grave doubts as to the value of his discovery of inoculation for the cure of hydrophobia.

Many of these patients come to him from long distances in France, many from other countries, and the evidence they bring of having been bitten by rabid animals, is exceedingly imperfect, and I think it is frequently impossible to determine whether they are suffering from the effects of hydrophobic virus or not.

I am quite certain that Professor Pasteur is sincere in this matter, and believes he has made a discovery which will greatly benefit mankind, but I confess personally I feel the evidence in favor of inoculation is very defective, and time only can determine whether it will be of value or not.

On leaving, I thanked Professor Pasteur for his courtesy, and expressed to him the pleasure that the medical profession of the United States would feel if he should be able to attend the meeting of the International Medical Congress of 1887. He thanked me and said that the investigations and labors he was engaged in would prevent him from attending.

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THE COMMITTEE ON PUBLICATION of the Massachusetts Medical Society, Shattuck Prize, are authorized to offer a prize of one thousand dollars for an essay, worthy of a prize, on The Climate and its Modifications as Influencing Health and Disease, or on any of the Disease of the Inhabitants of New England, or on any kindred subject. Essays, each with a sealed envelope containing the author's name, must be delivered to the Chairman of the Committee on Publications on or before March 1, 1888. The name of the successful competitor, if such there be, will be announced at the annual meeting of the Society in 1888.

*Any clew by which its authorship is made known to the Committee will debar an essay from competition.*



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BALTIMORE, OCTOBER 23, 1886.

**Editorial.**

THE CREMATION OF NIGHT SOIL AND GARBAGE.—One of the most difficult problems with which modern sanitarians have to deal, is the final disposal of organic refuse matters in cities and other places where many people are aggregated together. The reprehensible practice of emptying sewage, garbage, and night soil into streams or other bodies of water which may be sources of water-supply, is too dangerous to be much longer tolerated. On the other hand, the attempts to derive pecuniary profit from city wastes by converting fecal matter and garbage into manure, have generally resulted in failure, both in Europe and in this country.

For several years sanitarians have sought in fire an agent which could be used for the safe, efficient and economical destruction of organic refuse. Many methods for its use have been advocated by writers, and in some English and Scotch cities the cremation of garbage is an accomplished fact. In the United States an attempt at a practical solution of the problem is now being made in the city of Wheeling, West Virginia.

Dr. George Baird, in a paper read at the recent meeting of the American Public Health Association, in Toronto, gives an account of the Wheeling experiments, from which we take the following salient facts, which incidentally exhibit the difficulties to be overcome in this method of dealing with garbage and night-soil:

The first experiments were made in a bench of five retorts at the city gas works. The night-soil was mixed with fifty per cent. of fine slack, and three retorts were charged with this mixture. The other two retorts were charged with a mixture of equal parts of night-soil and "breeze" (fine coke siftings). The retorts were charged at 11 P. M., and it was not until seven o'clock the next morning that the contents were reduced to a fine, odorless powder. Another experiment of the same kind showed that retorts were not the proper things for successful combustion, owing to the want of a full supply of oxygen. It was then determined to find a furnace with a strong draught and capable of producing a greater heat than could be obtained in the retorts. The "boiling furnace" of a nail mill was then prepared for a third set of experiments. After twenty-four hours' heating a charge of twenty per cent. of fine slack and eighty per cent. of night-soil was made, and it was entirely consumed in one hour and twenty minutes. A second charge of "breeze" and night-soil was made and it was burned in a little more than an hour. A third charge of night-soil alone was made and was burned in about the same time as the first charge.

A fourth series of experiments was made in a Smith gas furnace used for the heating of steel slabs preparatory to being rolled into nail-plate. This furnace is said to be capable of generating a more intense heat than any other known. The results were as follows: A barrel of ordinary garbage or slop was burned in four minutes; a barrel of butcher's offal, (bones and animal matters) in seven minutes; a barrel of fluid night-soil, thrown into the furnace with buckets, was almost instantly evaporated, and a barrel of solid feces was totally consumed in fifteen minutes. The committee of the Common Council, which had charge of the experiments reported in favor of the adoption of the method of cremation for the disposal of garbage and fecal matter, and recommended the Smith furnace as the one best adapted to secure the result desired. A contract has been made for the con-

struction of a furnace capable of destroying sixty tons of garbage and night-soil daily, besides burning all dead animals which may die within the city limits, as well as the refuse matter from butcher shops.

In Wheeling, natural gas is to be used as a fuel on account of its cheapness and great heating power. For cities where natural gas cannot be obtained, the inventor of the Smith furnace has attached gas generators for the purpose of furnishing gas for combustion. The furnace for the city of Wheeling, which now has a population of about 35,000, will not cost over twenty-five hundred dollars.

In the city of Montreal, all night-soil has been burned for over a year, with perfect satisfaction to the citizens and city health authorities. The furnace is located about two miles from the city limits. It is said never to be offensive, all noxious gases being consumed. The cremation is done by contract, the contractor receiving \$4,000 per year, for five years. The contractor has the sole right of emptying the privy pits, for which he charges seven cents per cubic foot, which is paid by the property owner.

The garbage of Montreal is also destroyed by burning. The contractor is obliged to remove all garbage from the streets two or three times a week and burn the same. For this service he receives \$42,000 a year, his contract being for five years. The garbage has only been cremated since the first of August, but the medical health officer, Dr. La Berge, assured the writer, on the occasion of a personal visit recently, that the process is entirely successful.

These results should stimulate other communities to like endeavors. Especially in this city, where the final disposal of fecal matter and garbage is becoming such a serious problem, should the attention of the City Council be directed to this reform in sanitary administration.

**HEREDITARY DISEASES AND RACE-CULTURE.**—That hereditary influences are largely responsible for the physical deterioration of modern races of people

cannot be denied. The law of selection has worked just the reverse condition of physical development among the lower animals to that observed among human races. The physical type is the basis of selection among the former, whilst mental superiority, social influences, pecuniary interests, religious sentiments and various moral causes, all determine the choice among the latter. With few exceptions, the human races have disregarded the great advantages of physical superiority. The Greeks and Romans placed a high premium upon physical force and skill, and so long as these races took care of the physical welfare of their citizens and maintained the highest standard of physical endurance, courage and abstemious hardihood, just so long did their soldiery and citizenship manifest the highest patriotism. When the physical man became subordinated to the purely intellectual in the standard of citizenship, when habits of self-indulgence and of sensual pleasure were fostered and promoted by a vicious and corrupt society, the moral and physical degeneration of these races began and were continued until the Grecian phalanx and Roman legion ceased to be a terror to their semi-barbarous enemies.

The tendency of mental growth has been to dwarf the physical, not by reason of the necessity for the sacrifice of the latter at the expense of the former, but as the outgrowth of a false notion that the mental faculty may be cultivated at the expense of physical vigor without detriment. It has come to pass by reason of erroneous customs and false views of life that our civilization has been perpetuated along lines which show everywhere the deleterious influences of unnatural selections. Many of our statesmen, soldiers, philosophers, scientists and educated citizens, without regard to classes, present most marked types of intellectual superiority and brain power developed at the expense of physical power. That a vigorous mind may dwell in a diseased body is a well established fact. But behind all this apparent strength of nerve force, will-power and culture of mind, the influence



of the physical upon the mental is too apparent to be disguised. Witness the results of this unnatural selection in the progeny of such individuals and the story of hereditary influences is soon told. How many generations of statesmen, of soldiers, or of highly intellectual and specially endowed individuals are perpetuated into the second, third or fourth generations? The answer is significant to any who will observe. That hereditary diseases and race-culture develop side by side is a fact so well established as scarcely to admit of argument. We have before us a very carefully written and instructive article from the pen of Dr. George J. Preston, of this city, in the *Popular Science Monthly*, (September 1886) in which this subject is reviewed and presented in a very conclusive argument. Dr. Preston attempts to account for the physical degeneration of modern races of people through the influences of modern civilization, which pursues a course for the preservation of human life just the opposite of that enforced by the lower animals. He cites the history of the Spartans to show the low esteem in which the physically degenerated individual was held by the state, and then compares the work of modern civilization in its aim to nurture the diseased and imperfect specimens of our race. Hospitals and sanitariums are erected to perpetuate lives branded with hereditary taint, which are thus tided over infancy and childhood to propagate their kind. "All of this accords with our enlarged notions of humanity and reflects great credit on the zeal of the philanthropist and the science of the physician, but it exerts a baneful effect upon the race."

Consumption and insanity Dr. Preston takes to be the most prevalent of all hereditary diseases and those most apt to be perpetuated by the non-observance of the laws of natural selection. "We know of no government" says Dr. Preston "sufficiently strong to forbid the banns of a man whose lungs are full of tubercle, or of a woman upon whose person cancer has shown itself. The only way to begin to stamp out hereditary disease is to direct the tide of public

opinion towards it." Dr. Preston would not have the Spartan law enforced if he could, but he would have our people educated to the importance of this subject. "Those who are to become the fathers and mothers of our next generation should be warned before they make a step into the dark and should feel that it is a duty they owe, not only to themselves, but also to their country, to propagate a pure race." That the human race can be improved, Dr. Preston argues by analogies from among the lower animals. "How paradoxical it seems that a who would scout the idea of breeding his stock to diseased animals should yet without a word of opposition, see his children marry into families where the hereditary taint is marked. Yet such is undoubtedly the fact." Dr. Preston takes issue with the theory that healthy blood on one side of the house is sufficient to counteract the diseased of the other. "The predisposition to hereditary disease will often survive many influxes of pure blood, and the currents may, like the clear and sparkling Rhone emerging from Lake Geneva, and the dirty-gray Arve from the glaciers, run side by side for a while, separate and distinct, but at last they mingle, forming one turbid stream."

Our space does not admit of a fuller notice of Dr. Preston's admirable article. We commend the tone and spirit of its suggestions to the medical profession.

Clearly, there is a work for the profession in this important field of thought and action. That we have an influence in moulding and directing public thought into healthy channels cannot be denied.

The influences of heredity upon domesticity and marriage are subjects upon which physicians can converse in the sick room or in the family circle. Much license would be allowed to any discourse upon this subject which was not made personal in its application. By creating an interest in the subject or by suggesting lines of conduct in connection with the same much subsequent injury might be prevented among people exposed to unnatural and injudicious alliances. The sanctity of the

marriage relation is made to conform too much to unnatural aims.

Men and women too often wed with false views of the marriage relation, and through their ill-advised union in wedlock entail upon themselves and upon their posterity physical and mental legacies of the most injurious character. We have no idea that marriage alliances can be wholly regulated upon a strict basis of natural selection, but we fully agree with Dr. Preston in the belief that public attention should be directed towards this evil of our civilization.

### Book Reviews.

*A Treatise on the Principles and Practice of Medicine.* By AUSTIN FLINT, M.D., L.L.D. Assisted by W. H. WELCH, M.D., Professor of Pathology in Johns Hopkins University, and AUSTIN FLINT, M.D., L.L.D., Professor of Physiology in Bellevue Hospital Medical College. Sixth Edition. Philadelphia: Lea Brothers & Co., 1886.

The book before us is not a new work on medicine; it is the record of a busy life; the result of more than a half century of close observation; the study of disease among all classes of society. In it we have the words of a man who wrote not what he thought, but what he knew; not fancy but fact.

It is a book that the student can study from cover to cover, and one in which the overworked practitioner can obtain just what he wants. The clinical descriptions are photographic in their accuracy, and the remarks on treatment concise and always to the point. The value of the book is very much enhanced by the admirable introductory chapters by Professor Welch, and the remarks on pathology throughout the book bear the impress of the same gifted hand.

This edition contains all the recent views concerning micro-organisms and their connection with disease and is in every way up to date. The press work is done in that excellent style which has become characteristic of Lea Brothers.

*How We Treat Wounds To-day.* By ROBERT T. MORRIS, M.D. New York: G. P. Putnam's Sons. Second edition.

The author begins his preface by alluding to the "enthusiastic reception" of his first edition, and goes on to say that "the extinction of the exotic sensatism of trepidation and anxiety which formerly made operative work in surgery a mitigated and uncertain joy, will be the task again and again assigned to the book in its successive editions." Now we would not discourage the author in his laudable purpose to increase medical literature, but would mildly suggest that he would "assign a task" to himself which is not quite so Herculean.

We cannot at this moment recall ever having experienced the "exotic sensatism of trepidation \* \* \* mitigate our joy," but we may say, confidentially that the author's quixotic style of expression has to a considerable degree mitigated our appreciation of his book.

A "professor of surgery of thirty years experience" is handled in such a crushing manner that he doubtless apologized for being a "moss back" and sent in his resignation, and poor Lawson Tait is held up to execration.

Although the author doesn't quite say so, he at least implies that if Mr. Tait would only read this book he would "make his methods altogether good."

After far too much of this preliminary twaddle, the author gives concisely the various methods of using antiseptics in the treatment of wounds, and many suggestions concerning surgical dressings, which while they are by no means new, are for the most part reliable.

His style smacks of the recitation room; he is very fond of syllogisms and has evidently taken Tupper for his model, although the startling exclamations points remind us of Conway.

He closes with the sentence, "Beware of failure to recover." We pondered for sometime over these mysterious words, and finally came to the conclusion that they were intended for the reviewer who is now and then compelled to read books as remarkable as the one in hand.



### Miscellany.

NOTES ON THE TREATMENT OF BRIGHT'S DISEASE BY PROF. DA COSTA.—In considering the treatment of an affection or condition known under the general term "Bright's Disease," we must bear in mind that it exists in the acute and chronic forms; and for practical purposes the chronic is divided into three varieties: 1. Chronic tubal nephritis, chronic parenchymatous nephritis, or large white kidney of Todd. 2. Small contracting kidney, chronic interstitial nephritis, sclerosis of kidney or granular kidney, 3. Waxy kidney.

*Acute Bright Disease.*—In treating the acute form it is practically the same, no matter of what origin. The prognosis is generally favorable, but, rarely, it will when complicated with serous inflammations prove fatal. Rest the kidneys by bland, unirritating diet, milk being the best, combined with broths, eggs, or oysters. Insist on absolute rest in bed: if seen early may use with good advantage wet or dry cups over the kidneys. Medicinally, the infusion of digitalis f3j-f3ss every third hour is the best remedy, especially useful if the urine is dark and smoky. Another good remedy is pilocarpus, which may be given with or without digitalis, in doses of gtt. xv of the fluid extracts every six hours. Care must be taken if patient be at all weak. Hot or vapor baths daily or every second day do much good. Keep the bowels regular by Rochelle salts, jalap powder (compound), etc.

When the acute symptoms are over and the blood has disappeared from the urine, keep up laxatives and maintain diaphoresis, but now has come the time for iron, either the tincture of the chloride or Basham's mixture. When the patient goes out, keep him well protected, to prevent relapse.

For complications: in serous inflammation, with or without effusion, use the same general treatment, and also active purgatives. Uræmic symptoms also demand active purgation; enlural is invaluable if nervous symptoms arise, in doses of gr. x-xv every three or four hours, ac-

cording to the indications. Chloroform also is a powerful remedy indicated by the same symptoms.

*Chronic Bright's Disease.*—1. Chronic parenchymatous nephritis. Treat as far as possible on milk diet. For dropsy use laxatives and mild diuretics. Rest is indicated, much the same as in acute, also the preparations of iron. In England it is a routine practice to use counter-irritation over the kidneys; croton oil seems to be preferred. Nitroglycerine, gtt. j-ij of the 1 per cent solution, will diminish the amount of albumen in the urine, but not permanently. As a remedy having action it is worth trial, as is also f3ss of the fluid extract of ergot ter die.

No matter what course of treatment be adopted, with one remedy or another we must keep up the secretions of the kidney. As regards prognosis in this affection, as long as there are no marked fatty casts to be seen with the microscope do not despair of cure. The gravity of the case depends on the fatty degeneration.

2. Chronic interstitial nephritis. Aim to lessen the production of fibrous tissue, by administering the iodide of potassium or the bichloride; especially are these remedies indicated if there be any syphilitic history. The iodide of iron is also to be recommended as the case tends toward a uræmic condition.

One thing always to be done is to keep the kidneys well washed out by any stimulating non-depressing diuretic. We need not attempt to check excretion of albumen. Keep urea out of the patient's system by free action of the bowels and skin. The prognosis is favorable as to life not however as to cure, though a great deal can be accomplished by treatment.

3. Waxy kidney. The treatment should be active and early. Give large doses of iodide of iron and cod-liver oil, varying with arsenic. Ammonium chloride in decided doses is often successful. Maintain free action of kidneys, bowels and skin. Give good nutrition, open air and change of scene.—*College and Clin. Rec.*

**IODOFORM IN THE TREATMENT OF SYPHILIS.**—Iodoform has been tried partly as a substitute for mercury by those opposed to mercurial treatment of syphilis, and partly in place of iodide of potassium in the treatment of the tertiary forms of syphilis. The estimation of various observers of the value of iodoform as an antisiphilitic remedy varies materially. Von Maitre recommended first its internal use in syphilis, and claimed that 45 grains could be ingested daily with impunity. Davenport\* gave it in secondary syphilis together with iron. Lazanski gave daily to twenty syphilitic patients (tertiary form) six to eight pills each, consisting of  $1\frac{1}{2}$  grains of iodoform, and pronounced the action of the drug very efficacious. Moleschott,† likewise, eulogized iodoform in syphilis, and called attention to the fact that this drug is much more slowly eliminated from the economy than mercury, and is for this reason therapeutically more active than the latter.

Other authors, however, like Zeissl, Strokowski, Tarnowski, and Mracek, after careful and numerous observations, have come to the conclusion that iodoform given alone internally in syphilis is but little reliable and useful. It is to be added that the drug causes certain secondary symptoms, such as gastric disturbances, vomiting, an acne-like eruption, nervousness, rendering its exhibition practically ineligible. Although the percentage of iodine contained in iodoform is much larger (96 per cent.) than that contained in iodide of potassium (76 per cent.), it is, nevertheless, possible to introduce into the system by the latter drug in a short time far greater quantities of iodine than by the former. Besides, iodoform cannot be taken with impunity in larger daily doses than 15 grains, while of iodide of potassium much greater quantities are well borne.

The result obtained with subcutaneous injections of iodoform, as proposed by Bozzi in 1870 and Thomann‡ in 1881, are sufficiently satisfactory to en-

gage out interest. The latter employed the glycerite of iodoform (6 to 20), and iodoform dissolved in oil of almonds† (0.3 to 6), using as an average dose as much as 12 grains of iodoform. Both in recent and tertiary syphilis these authors obtained very gratifying results, 3 to 4 dr. of the drug being required for the cure of tertiary lesions. The local reaction after injection of iodoform is immaterial; the pain soon passes away, as do the induration and redness of the place of injection. An abscess has been recorded in only a single instance. Neumann used besides glycerin still other vehicles for his subcutaneous injection of iodoform, such as ether (1 to 6), castor oil (1 to 15) and ether and olive oil (5 āā).

Neumann found by experiments on animals that from the glycerite of iodoform  $\frac{1}{3}$  grain of iodoform, and of the solution  $\frac{2}{3}$  grain of iodoform were resorbed daily. In a case where Mracek had given in thirteen days  $1\frac{1}{2}$  dr. of iodoform, he noted the elimination of the drug in the urine for a period of forty days. In another case, Thomann found iodine in the urine forty three days after the last injection of the glycerite of iodoform. These observations demonstrate that the glycerite of iodoform applied subcutaneously acts similarly as calomel applied hypodermically: from the drug deposited into the cellular tissue small quantities are being constantly and for a long time dissolved, and enter the circulation. This peculiar action of iodoform renders the drug particularly eligible in the light tertiary forms, while in the grave gummy processes, necessitating the introduction of larger quantities of iodine, iodide of potassium, being more rapidly and in greater quantities resorbable, is far preferable. In conclusion, the beneficent action of iodoform in syphilitic neuralgia is to be mentioned. Daily doses of 15 grains of iodoform taken in pill form, are regarded as a promptly-acting remedy.

To resume the above, we find iodoform

\* *Boston Med. Journal*, 1873.

† *Wein. Med. Woch.*, 1878.

‡ *Centralblatt fuer die Med. Wiss.*, 1881.

\*Solution of iodoform are to be preserved in a dark bottle, else iodine will be liberated, and applied hypodermically will prove highly irritating.



as an antisyphilitic remedy inferior to iodide of potassium, surpassing the latter only in syphilitic neuralgia. Employed subcutaneously, however, the drug, especially in the light tertiary forms, produces a far more constant and effective action on the organism than iodide of potassium.—*Ther. Gaz.*

**RUPTURE OF THE BLADDER**—The result of suturing the rent in cases of ruptured bladder has not hitherto been successful, but the opinion held by surgeons that it is the right treatment to pursue in such cases, receives strong confirmation from a case now under the care of Sir William MacCormac in St. Thomas's Hospital. The patient, a strong, florid, healthy man, aged thirty-three, injured his abdomen by running up against a post, about fifteen hours before he applied for admission. Interrupted silk sutures were used for the bladder, the rent in which was about three inches long, a catheter was tied in, and the abdomen drained by a glass tube. There was a large amount of urine in the peritoneal cavity, which was washed out with a solution of boracic acid. The operation was performed on the 22nd ult. The patient passed urine the following day, when the catheter was removed. The drainage-tube was taken out on the 24th, and there has been no fever or other symptoms since the operation.—*Lancet* Oct. 2, 1886.

**TRAUMATIC PLEURISY.**—Dr. Seved Ribbing reports, in the Swedish *Eira*, amongst a number of instructive cases, the following one of traumatic pleurisy. A man, who had received a blow on the right side of the thorax in a drunken quarrel was admitted into the Cimbrishamn's Hospital with the ordinary signs of pleurisy with effusion. The cavity was consequently aspirated, the puncture being made in the eighth intercostal space just below the angle of the scapula. The signs of fluid returning, it was decided to open up the cavity. This was done by an incision in the same situation as that in which the aspiration had been performed, and a quantity of thick fibrino-purulent matter evacuated,

a large French œsophageal sound being used for drainage. Two days after the operation it was noticed that the integuments and superficial muscular layer around the shoulder-joint flapped like a curtain at each inspiration. As this pointed to the existence of an abscess cavity communicating with the chest, a sinus was searched for and discovered running upwards from near where the opening into the thoracic cavity had been made. This sinus was laid open, and, together with the chest, carefully drained and washed out with carbolised water. The quantity of fluid which came away diminished daily; the temperature, which had been high, sank; and in three months' time the man was discharged cured.—*Lancet*, September 18, 1886.

**THE TREATMENT OF RHUS-POISONING**—Dr. Frederick W. Putnam, of Binghamton, N. Y., writes to the *Therapeutic Gazette*:

It is my fortune every season to see quite a goodly number of cases of rhus-poisoning, and I wish to emphasize a plan of treatment for this annoying trouble, already mentioned by Dr. Morrow in the *Journal of Cutaneous and Venereal Diseases*, and copied in the *Gazette*.

My treatment is simply a saturated solution of bicarbonate of sodium. I saturate strips of muslin in this solution, and apply them evenly over the surface, and then endeavor to keep the surface thoroughly moistened with the solution until the dermatitis subsides. I do not give any medicine internally. There is nothing new about this plan of treatment, but it has been entirely successful in my hands in every case.

**ICHTHYOL IN CHRONIC URTICARIA.**—We abstract from the *Wiener Medicinische Blätter* of August 5, 1886, the following therapeutic note regarding ichthyol:

According to Unna, we possess in the salicylate of sodium and in atropine two remedies against chronic urticaria, which are ordinarily wholly reliable. Still, there are cases in which not only

these drugs but the entire host of nervines fail, and ichthyol alone brings relief and cure. The following two cases may serve to illustrate this fact:

1. Miss S., æt. 22, chlorotic; presented for treatment March, 1885, for an extended urticaria, existing four weeks. Salicylate of sodium was given in the largest doses for several days without the slightest benefit. Atropine internally (0.0005 *ter die*), painting with equal parts of spir. saponat. and tinctur. bellad., decoction of valerian, and iron pills brought on an improvement, which, however, soon disappeared again. Ichthyol (pure) taken in five-drop doses three times daily, and applied also externally, established a perfect and lasting cure.

2. Vigorous man; treated by other physicians without success for an urticaria of several weeks' standing. Unna prescribed ichthyol, to be employed internally and externally, and again effected a perfect cure.

In neither case did any relapse appear. —*Therapeutic Gazette*.

THE PROGRESS AND PREVALENCE OF BALDNESS IN AMERICA.—The subject of baldness is one that oftener awakens facetious comment than serious investigation. Mr. Virgil F. Eaton, however, has recently published in the *Popular Science Monthly* the result of a very extended inquiry into the causes and prevalence of premature loss of hair among American men. Mr. Eaton's method has been to visit public assemblages of every character and count the bald heads. He finds that in most of the Eastern cities fully thirty per cent. of the men over thirty years of age show unmistakable signs of baldness, while nearly twenty per cent. have spots on their heads that are not only bald, but actually polished with the gloss that is supposed to belong to extreme old age alone. New York and Boston take the lead in the proportionate number of bald pates, and after these come Philadelphia, Washington, and the Western towns. Mr. Eaton discovers, too, that the more refined the show, the more fashionable the church, the greater is the proportion

of bald heads. For instance, when Patti was singing at the Boston Theatre, forty-two per cent. of the men on one occasion and forty-six per cent. on another were baldheaded, while at John L. Sullivan's exhibition of the manly art only twelve per cent. of the men in Mr. Eaton's vicinity were bald. He also found that forty-six per cent. at one of Matthew Arnold's lectures, and less than twenty-five per cent. at a variety theatre exhibited baldness or signs of baldness. At the fashionable Trinity Church of Boston, nearly half of the men were either actually bald or on the road to baldness.

Mr. Eaton's curious observations, therefore, tend to confirm the view that the coming man is to be bald, and that the per cent. of baldness is in direct proportion to amount of education and cultivation which a community receives. —*Med. Record*.

SIR JOSEPH LISTER'S OPERATIONS.—The correspondent of the *American Practitioner and News*, writing from London, who has watched Sir Joseph Lister operate, says that he is excessively slow, and is by no means careful in details of antiseptis. He has given up the spray entirely, and is now using for dressings gauze and cotton impregnated with a new antiseptic. The nature of this is at present a secret. The correspondent confessed that he "had the cheek to ask Sir Joseph for information on the subject, when he very politely replied that he was sorry to have to decline giving it to me, that it is yet a secret, and he wished to keep it as such until he was fully satisfied as to its efficacy, when he would make it known to the profession. He said that it had been on trial in his wards for many months, and that so far he was greatly pleased with it."

COLD APPLICATIONS TO THE PRÆCORDIA IN FEVER.—In the *Practitioner* (Aug., 1886,) Dr. F. T. Grigorovich publishes the results of this mode of treatment of fever employed in the Rostoff Military Hospital. His observations were made on uncomplicated cases of typhoid fever,



He finds that the respiration, at first somewhat quickened and rendered irregular by the reflex actions, subsequently becomes slower. At the end of the application of the ice and the next morning it is deeper and more regular, but somewhat slower than before the ice was applied.

The general conclusions regarding the effect of applying cold to the region of the heart are as follows :

1. The cold undoubtedly reaches the heart itself, and thus produces an effect on its action.

2. This effect is particularly noticeable when the cardiac beats are increased in frequency in consequence of a high temperature quickly attained, and where a certain degree of sensitiveness to a high temperature exists.

3. The effect of cold is not marked at the end of a prolonged attack of fever, pathological changes having by that time probably become established in the cardiac muscle.

4. The local application of cold is only capable of protecting the heart-muscle from the effects of a high temperature when it is applied assiduously from the commencement of the disease.

5. Under its influence the action of the heart improves, the number of beats diminishes, while their force and amplitude increase.

6. Cold applied to the region of the heart diminishes the gravity of the *typhoid* condition and favorably influences the respiration.

7. With regard to the effect of cold applied to the region of the heart on the course of the general temperature, the author cannot at present express a decided opinion, as he did not investigate the question; but in the results which he obtained indications may be found of the possibility of its causing some diminution of the temperature.—*Therapeutic Gazette*.

**COLD BATHING.**—*The Lancet* says the use of cold water as a bath for ordinary health purposes—we are not speaking of its use for the strictly medical purpose of reducing the temperature of the body in certain states of disease—is

purely reactionary. The cold bath is only useful, or even safe, when it produces a rapid return of the blood to the surface immediately after the first impression made, whether by immersion or affusion. The surface must quickly redden, and there must be a glow of heat. If these effects are not rapidly apparent, cold bathing is bad; and no such effects are likely to be produced unless the circulation be vigorous and both the heart and bloodvessels are healthy. Great mistakes are made, and serious risks are often incurred, by the unintelligent use of the cold bath by the weakly or unsound. Moreover, it is necessary to bear in mind that there is seldom too much energy to spare after middle age, and it is seldom expedient for persons much over forty to risk cold bathing. We would go so far as to say that no one above that age should use the tub quite cold unless under medical advice. It is possible to be apparently robust and, for all the average purposes of life, healthy, and yet to have such disabilities arising out of organic disease or weakness as to render the recourse to heroic measures, even in the matter of cold bathing perilous.

**PIPERINE IN INTERMITTENT FEVER.**—Dr. C. S. Taylor reports in the *British Medical Journal*, September 4, 1886, two cases of intermittent fever which were treated by the administration of 3 grains of piperine every hour until 18 grains had been taken, as soon as perspiration commenced to follow the malarial paroxysm. On the following day, when the intermission was complete, the same quantity was directed to be taken every three hours. According to Dr. Taylor, this treatment in every case succeeded in checking the paroxysm. As soon as this is accomplished, he advises the use of the following pill, the employment of which has always seemed to be very beneficial:

R Blue mass, gr. 1;  
Piperine, gr. 2;  
Sulphate of quinine, gr. 3:  
Syrup, q. s.

INOCULATION OF TUBERCLE.—Now that we possess a proof of the tubercular nature of a disease in the presence of the specific bacillus, the idea of communicability of the disease which was held by the older authors is capable of demonstration, and many cases have been recorded which leave little doubt that such an origin of the disease is far from infrequent. Among the latest cases of this kind is one related by Dr. Elsenberg in the *Berliner Medizinische Wochenschrift* for Aug. 30th, in which the disease was communicated by a curious custom which prevails among the lower classes of the Jews, of sucking the wound on the penis after the rite of circumcision has been performed. From this custom the author has seen syphilis communicated, and latterly undoubted tubercle. Lindman recorded two and Lehmann ten cases in the *Deutsche Medizinische Wochenschrift*, in which it was thought that tubercle was transmitted from one to another in this way, and it is a noteworthy fact that Lehmann's ten cases were all produced by the same person, who shortly after died phthisical. The case which Dr. Elsenberg records, was a child born in the month of September of perfectly healthy parents, which was circumcised on the eighth day and the wound sucked as usual under the idea of stopping the hæmorrhage and cleansing it; but instead of healing, as customary, the wound spread and formed an ulcer, the lymphatic glands became affected, and in the month of February the child was placed under the treatment of Dr. Elsenberg; but death ensued in the month of March, and in the foreskin and glands tubercle bacilli were found by the Ehrlich-Weigert method. The next step to complete the observation was to examine the man who had sucked the wound. This at first disclosed nothing of importance, but it was found that he coughed at times and brought up some mucus; some of this obtained after prolonged coughing was examined, and found to contain bacilli.—*Lancet*.

"MIST. NIGER."—Is a favorite mixture of Prof. Wm. A. Hammond, which

he has used for years with great success and satisfaction. It is appreciable in cases where the bromide is indicated and dyspepsia is present, etc.

Dr. Charles Henry Brown has used it very generally in the clinic, and considers it a very valuable formula. He slightly changes the original by specifically denoting the quality of drugs used, viz.:

R Sodii bromidi (Merck's), - - - 3 i.  
Pepsin (Jansen's or Fairchild's scale), 3i-3ii.  
Pulv. carbo ligni (Bullock's), - 3 ii-3 iii.  
Glycerine, - - - - - 3 ss.  
Aquæ menth. virid, - - - ad. 3 iv.

M.

SIG.—3 i. three times a day after meals.  
Dilute well.

—*The Quarterly Bulletin*.

RACE AND PROGRESS.—Few travelers who have crossed the borders of Virginia and Kentucky, going South, have not been struck with the aggressive spirit that characterizes the states to the north, and the conservatism among the people of the states named. Many would at once conclude that the difference in the two sections is due to slavery. But if we travel further South, we find that South Carolina, Georgia, and Alabama are much more easily stirred than the people of the states to the North of them, and this, notwithstanding that they were still more under the domination of slavery. It seems relatively much easier to get up manufacturing enterprises, or social, or political movements of any kind in the extreme Southern States named than in the belt to the North of them.

Slavery has had very much to do, no doubt, in retarding the South, but the remarkable differences referred to seem in a great measure due to differences in the character of the people who first colonized the Atlantic coast and spread westward on lines of latitude. The energetic, pushing, enterprising, aggressive, and often tyrannical Puritan first settled New England, and, pushing to the West and Southwest, carried the leaven of Puritanism to the line of the slave states, overrunning to a greater or less degree the entire North.

Virginia and North Carolina and



their daughters, Kentucky and Tennessee, were dominated by the Cavalier. Proud, brave and magnanimous, they held themselves to be the best of people, and all they had was the best, if only because it was theirs. Hence they were steeled against all innovation, and took slowly to new enterprises of any character. But South Carolina, Georgia, and Alabama felt the influence of a different spirit. There the leaven of the Huguenots was working. The progressive, refined, receptive people driven out from France by the revocation of the Edict of Nantes, who did so much for Germany and England, carrying with them all the high qualities of culture that have so long characterized the capital of France, have stamped their impress upon a wide territory of the New World. But a change has come, and with altered aims the soldierly Cavalier now enters the lists with the Puritan and Huguenot in material progress. — *Prac. and News.*

THE PHYSICIANS OF THE UNITED STATES.—In a recent directory of the physicians of the United States, published by Polk, the total number is given as 85,671, of whom 83,239 are males, and 2,432 females. This makes the ratio of physicians to population about one in 650, allowing for the increase in population since the last United States census. Maryland is the most crowded state, having but 320 people for each physician. Other crowded states are Colorado, 341; Indiana, 396; Oregon, 353. All the remaining states are above 400. New Mexico has relatively fewer physicians than any other state or territory, with 1,494 people to each medical man. The remaining states and territories coming above the one thousand mark are Utah, 1,035; North Carolina, 1,029; South Carolina, 1,084. Ohio has 502, and Kentucky, 551. There are relatively more physicians in Ohio than in either Maine, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, or Pennsylvania. Taking the table before us as a guide, the "vacancies" exist in New England rather than in either the Cen-

tral or Western States. There are relatively more physicians on the Pacific coast than on the Atlantic.—*Medical Record.*

INFLUENCE OF THE FALLOPIAN TUBES AND OVARIES UPON MENSTRUATION.—In a paper on the Pathology of the Fallopian tubes, published in the *Deutsche Medicinische Wochenschrift*, Dr. A. Martin, of Berlin, says, with reference to the theory of Mr. Lawson Tait, that the Fallopian tubes have an important influence upon menstruation, that he carries this very far when he argues that "castration performed with the object of diminishing uterine myoma, should not imply removal of the ovaries, but rather of the tubes." And he (Martin) then relates a case where, in 1882, the right Fallopian tube of a patient and the diseased part of the right ovary were removed, the rest remaining. The patient was relieved for a year, then suffering began on the left side, and in February, 1883, a hæmato-salpinx was discovered on the abdominal section, and the left tube was removed with the whole of the left ovary. Martin says: "I have often seen this patient since March, 1883. Although she had no Fallopian tubes, and only a part of the right ovary, which was left in February, 1881, she menstruates regularly." And he concludes thus: "As this patient menstruates regularly without tubes, and with only a small remnant of one ovary, she is a striking illustration of the Tait theory!"—*Med. Rec.*

A NEW DISINFECTING COMPOUND for purifying the atmosphere of the sick-room has just been presented to the Berlin Medical Society. Oils of rosemary, lavender, and thyme, in the proportion of 10, 2½, and 2½ parts respectively, are mixed with nitric acid in the proportion of 30 to 1½. The bottle should be shaken before using, and a sponge saturated with the compound and left to diffuse by evaporation. Simple as it is, the vapor of this compound is said to possess extraordinary properties in controlling the odors and effluvia of offensive and infectious disorders.—*Medical Record.*

### Medical Items.

The American Association for the Advancement of Science contains a membership of 2,108, of whom 280 are physicians.

The eighth semi-annual meeting of the Association of the surgeons of the Pennsylvania Railroad Company was held in Pittsburg, Pa., on Tuesday, October 19th.

J. William White, M.D., has been elected Professor of Genito-Urinary Diseases in the Medical Department of the University of Pennsylvania.

The Nicolas Military Hospital in St. Petersburg has now a special department for the treatment of diseases by massage, and also a training-school for the instruction of nurses in the method of giving massage.

It is stated on the authority of the *Colonge Gazette* that the Minister of Public Instruction has just decided that women shall not be admitted, either as students or as attendants, upon lectures in any the of universities of Prussia.

The title of doctor was invented in the twelfth century, at the first establishments of the universities. William Gordenia was the first person upon whom the title of doctor of medicine was bestowed. He received it from the college at Asti in 1329.—*Med. News*.

The *St. Joseph Medical Herald* says that the late Samuel Ensworth has bequeathed a sum of about one hundred thousand dollars in trust for the erection and maintenance of the St. Joseph Medical College and a hospital to be erected in St. Joseph upon such a site as may be selected.

Maud—"And so you have dismissed Dr. A. and employed Dr. B.?"

Edith—"Yes, and I am only sorry I did not do it at first."

"But Dr. A. is a most excellent physician, known the country round, while this Dr. B. is an utter stranger."

"Yes, I know; but Dr. B. does not believe in cod liver oil."—*Ex.*

At a *conversazione* given last week at the Toronto School of Medicine, as we learn from a local journal, dancing took place in the dissecting room, which was gaily festooned with bunting, and uniforms of military officers, together with the ladies' evening toilettes, banished any grim suggestions of the place.—*Boston Med. and Surg. Jour.*

Dr. Baxter's tables show that out of 334,321 recruits and substitutes examined by the recruiting officers during the war of the rebellion, more than 17,000 were rejected on account of hernia. The London Truss-Society, during the first twenty-eight years of its existence, issued over 83,000 trusses. Two factories in Philadelphia manufacture and sell from 216,000 to 250,000 per annum. J. B. Hamilton in *Chicago Med. Jour.*

Mr. J. Sampson Gamgee, whose death was recently announced in this JOURNAL, was born at Florence in 1828. He was the son of an eminent veterinary surgeon (still living in Edinburgh). He was at first destined for the same calling, but subsequently became a student at University College and entered the medical profession, studying afterwards at Paris, Pavia and Florence.

The American Pharmaceutical Association at its last meeting adopted the following resolution:

*Resolved*, That this Association solicit the aid and coöperation of the American Medical Association, in promoting the prescribing by physicians of official medicines only, or such preparations as have published formulas, in preference to others; and that the several State Pharmaceutical Associations make similar requests of their respective State Associations.

The *Medical News* says: "At the recent banquet of the British Medical Benevolent Fund, Dr. Broadbent, in proposing the health of the Chairman, Sir James Paget, applied to him the words Sir James himself had used of Sir Thomas Watson: 'His knowledge was so vast, his goodness so great, and his example so elevating, that we all wished he might spend part of his immortality on earth.'"

Tarboro, N.C., is beginning to enjoy a widespread reputation as a health resort for consumptives. Among the improvements now going up in Tarboro is a large brick hotel, which is being built mainly for the accommodation of Northern visitors who make their winter homes there. It is stated on the authority of the oldest physicians of Tarboro that in the "Coneto" section adjoining the town, there is not on record a case of consumption.

Edgecomb County, North Carolina, has a very popular medical society, which meets monthly at the residences of its members. After discussing medical matters, the meeting winds up with a banquet. The society has not only stimulated an interest in medical work, but has promoted social and friendly relations between brother practitioners. Similar societies should be organized in every county in the State.

What fee should be charged a wealthy man for attendance upon his wife in confinement, more than four hours of day time being thus consumed, and several visits made the patient during convalescence, by a practitioner of more than 25 years' experience and occupying one of the most prominent positions among the medical profession of Detroit? Such was the question put to us the other day by another Detroit physician. Our guess was far too high, and yet we estimated the time at about plumber's prices. We doubt if any of our readers would nearer approximate the truth. As a fact we are ashamed to state the sum. It is no wonder that so many of the physicians of Detroit are so poor.—*Detroit Lancet.*



